Departmental Instruction 315 (QM)13
Reporting and Reviewing Unexpected Deaths

315 - 1 Background

The Department of Behavioral Health and Developmental Services (the Department) is committed to continually improving the health and safety of the individuals receiving behavioral health or developmental services in state hospitals and training centers. Rigorous inquiries into unexpected deaths can identify opportunities for systems improvements that will reduce risks to individuals receiving behavioral health or developmental services.

315 - 2 Purpose

The purpose of the Departmental Instruction (Instruction) is to establish policy and procedures that will ensure the thorough and consistent review of all unexpected deaths in order to identify trends, patterns, and problems at the individual service-delivery and systemic level that resulted in or contributed to the death, thereby enabling the Department to develop and implement quality improvement initiatives to improve services and care.

315 - 3 Definitions

The following definitions shall apply to this Instruction:

Expected death This means a death that was consistent with and derived from an individual's previously diagnosed terminal condition. The individual or family, or both, was aware that the illness or condition would result in death and had had an opportunity to discuss, if not decide, end of life matters and clinical measures to be taken or not taken. For some individuals the decline of the aging process may produce an expected death as well.

Mortality Review Committee This means the subcommittee of the Department's Quality Management Committee that is charged with reviewing all unexpected deaths and any other deaths the Committee may deem necessary to review to identify any systems failures that may have caused or contributed to the death, and take action to prevent or reduce the risk of another such death.

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Quality Management Committee

This means the Clinical Services Quality Management Committee, hereafter referred to as the Quality Management Committee that was established by the Department to carry out the following functions on a system-wide basis: (i) routinely examine the efficacy and appropriateness of clinical services; (ii) collaborate to make systematic efforts to improve performance; and (iii) share knowledge of problems and successful improvement strategies.

Unexpected death

This means a death that occurred as a result of an acute medical event that was not expected in advance or based on a person's known medical conditions. Examples might include a suicide, a homicide, an accident, an acute medical event, a new medical condition, or sudden and unexpected consequences of a known medical condition. An unexplained death also is considered an unexpected death.

315 - 4 Responsible Authorities

Facilities

Facility directors are responsible for:

- ensuring that processes and structures are established for the conduct of mortality reviews; and
- ensuring that all deaths of individuals receiving services in a state facility, whether unexpected or expected, are reported to the Assistant Commissioner for Quality Management and Development or designee and to the Medical Director within 12 hours of the death via Media Alerts.

Central office

The Department Medical Director is responsible for:

- conducting a rigorous inquiry into all unexpected deaths; and
- presenting summaries of the deaths, review findings, and recommendations to the Department's Quality Improvement Committee and its Mortality Review Committee.

315 - 5 Specific Guidance

Spirit of the mortality review

Research has demonstrated that individuals with serious mental illness or intellectual disability are at greater risk than the general population for dying prematurely. In addition to the medical, psychiatric, and cognitive complexity

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Spirit of the mortality review *(continued)*

they may experience, in many cases individuals with these conditions may be limited in their capacity to:

- attend to their own health issues;
- recognize the significance of their medical conditions; or, at times,
- communicate clearly about their medical symptoms or conditions.

Thorough and consistent mortality reviews assure that one legacy of each individual after his or her death is that the facility is changed for the better as a result of the review. The intent of the mortality review, therefore, is to:

- review each unexpected death and identify the systems failures that may have caused or contributed to the death, and
- take action to prevent or reduce the risk of another such death.

More particularly, the predominate purpose of the mortality review is to identify actions and processes that, if improved in the future, may mitigate the risk for an individual facing similar circumstances or risks. To this end, each facility should establish a culture that supports a rigorous inquiry into unexpected deaths of individuals receiving services for the purpose of identifying ways to improve care and treatment and facilitate growth in the capacity of facility staff to critically review events and processes within the facility.

Scope of the mortality review

Regulations or accreditation standards specify review requirements for deaths of individuals receiving services. However, even when a review is not required, a facility may determine that a particular death should be reviewed as part of its quality improvement process. The scope of the mortality review should include, but may not be limited to the sequence and nature of events as they unfolded, even going back premorbidly, to identify areas where there are opportunities to improve safety or practice through: training, change in procedure or process, change in communication, change in staffing, or by other means.

Expected vs. unexpected deaths

At times, the identification of a death as “expected” or “unexpected” is neither clear nor straightforward in the context of the individual’s medical conditions or the complexities that posed a chronic risk to him or her. For those cases that fall between the extremes of a clearly expected or unexpected death, the facility must take into consideration multiple variables when making a determination as to whether an individual’s death is expected or unexpected. These variables include the individual’s:

- age;
- chronic or acute medical conditions;
- the relationship between medical conditions and the likely cause of death;

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Expected vs. unexpected deaths *(continued)*

- medications; and
- other relevant factors, as defined by the facility.

An example of a clearly expected death is that of an 84 year old man with a diagnosis of dementia and multiple medical problems who has been eating and drinking less and less, sleeping more, withdrawing from others, and who contracts pneumonia. He is transferred to a local hospital where he is admitted to the ICU, where he makes a Durable Do Not Resuscitate Order (DDNR). Logically, this is an expected death, not because of the pneumonia, but because of the combination of the individual's age and his multiple medical conditions.

At the other extreme would be a suicide or accidental death.

An in-between example is a 35 year old woman with an intellectual disability who suffers a hip fracture with complications and dies due to a pulmonary embolus. This is an unexpected death because a person is not expected to die from such a fracture even though it is a known potential complication of the condition. A final example is that of a 48 year old man with liver failure, severe coronary artery disease, and diabetes. He is largely non-compliant with his medications and treatment. One day he collapses suddenly after walking up the stairs. In this instance, whether his death was expected or unexpected will depend on whether or to what extent his medical conditions contributed to his death.

315 - 6 Procedures

Reporting requirements for deaths in state facilities

All deaths in state facilities, whether expected or unexpected, shall be reported to the Assistant Commissioner for Quality Management and Development or his or her designee and the Medical Director within 12 hours of their occurrence, via Media Alert.

In addition, state facilities shall provide the following to the Department Medical Director within 45 days of the unexpected death of any individual receiving services:

- A factual summary of the important developments leading to the death. The factual summary shall include:
  - A list of current diagnoses and active medical problems at the point the episode began to develop;
  - The interventions, medications, and treatment related to active medical problems at that point;
  - Key developments in the course of illness leading to the death that include signs, symptoms, tests, exam findings, treatment provided, response to treatment.; and

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Reporting requirements for deaths in state facilities *(continued)*

- Information related to family contact and decision making.

The factual summary is NOT privileged and should NOT include a documented assessment or critique of the events.

- Recommendations from the facility's internal review of the death, to include a copy of the recommendations made to the facility Quality Council as a result of the facility mortality review.
- In addition to the factual summary and recommendations, training centers are required to send copies of the following to the Department Medical Director:
  - Physician progress notes for the three months prior to the death;
  - Nursing progress notes for the three months prior to the death;
  - Any incident reports for the individual during the three months prior to their death;
  - The most recent individualized service plan;
  - The death certificate; and
  - The autopsy report, if available.

Department Medical Director review of unexpected deaths

The Department Medical Director shall review the factual summary of the unexpected death and recommendations from the facility mortality review as well as any additional information provided. If indicated, further information from the individual's record or other relevant documents at the facility may be requested. The Medical Director also may collaborate with other Department employees in performing an additional review prior to the case presentation to the Mortality Review Committee.

Questions regarding the death or facility internal review and requests for additional information or documents at the facility shall be directed through the Department Medical Director to the facility director.

The Medical Director shall provide the Mortality Review Committee with the factual summary and recommendations from the facility's mortality review and the recommendations from his review of the unexpected death within 30 days of receiving this information from the facility.

Mortality Committee review of unexpected deaths

The Mortality Review Committee is comprised of the Department Medical Director, the Assistant Commissioner for Quality Management and Development (or designate), the Assistant Commissioner (or designate) from the relevant program area, a physician not otherwise employed by the Department, and others as designed by the Commissioner.

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Mortality Committee review of unexpected deaths *(continued)*

The Mortality Review Committee shall meet each month, as needed, to review information relative to unexpected deaths reported to the Department.

The Committee shall conduct its review within 90 days of the date of the individual's death. Committee findings shall be based upon its examination of:

- Medical records, including physician case notes and nurses notes, and all incident reports, for the three months preceding the individual's death;
- The most recent individualized program plan and physical examination records;
- The death certificate and autopsy report;
- Any evidence of maltreatment related to the death; and
- Interviews, as warranted, of any persons having information regarding the individual's care.

The Mortality Review Subcommittee shall prepare and deliver a report of its deliberations, findings, including notation of the unavailability of required information, and recommendations to the Quality Improvement Committee for consideration at its next quarterly meeting.

Mortality Committee analysis of mortality data

The Mortality Review Committee shall analyze mortality data collected by the Department to identify trends, patterns, and problems at the individual service-delivery and systemic levels and develop and recommend quality improvement initiatives to reduce mortality rates to the fullest extent practicable.

In addition to providing information regarding the deliberations, findings, and recommendations to the Quality Improvement Committee, the Mortality Review Subcommittee shall provide a summary of such information directly to the Assistant Commissioner for Quality Management and Development when the unexpected death has occurred in one of the training centers.

Quality Management Committee review of unexpected deaths

The Quality Management Committee is comprised of the Deputy Commissioner, the Assistant Commissioner for Quality Improvement and Development, the Assistant Commissioner for Developmental Services, the Assistant Commissioner for Behavioral Health, the Department Medical Director, and up to three members as determined by the Commissioner.

The Quality Management Committee shall meet at least quarterly to review the findings and recommendations of the Mortality Review Committee and shall develop and implement quality improvement initiatives to reduce mortality rates to the fullest extent practicable.

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Quality Management Committee review of unexpected deaths *(continued)*

Quality Management Committee findings, recommendations, or other information as deemed appropriate by the Committee shall be entered into a database for subsequent trend analysis. The Quality Improvement Committee shall receive quarterly summaries of unexpected death trends from this database.

At least annually, the Quality Management Committee shall review trend data to determine if there is a need for further review or action.

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315 - 7 References

Va. Code § 8.01-581.16 Civil immunity for members of or consultants to certain boards or committees

Va. Code § 8.01-581.17 Privileged communications of certain committees and entities

James W. Stewart, III
Commissioner

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