A. Performance Improvement: Review of Consumers Death for Mental Health Agencies

POLICY: It is the policy of the Division to review certain cases in which people receiving services die. Consumers who die while receiving services at Psychiatric Observation Units, hospital inpatient units or 24 hour residential facility will be reviewed according to Division Policy CRR-1.13 Sentinel Events.

PURPOSE:

The purpose of this review is to assess and make recommendations for improvements to the treatment and service delivery systems provided, thereby reducing risk for others receiving services. Recommendations stemming from these reviews will be used to promote performance improvement indicators and measures at all Division Agencies.

SCOPE: Division wide – Mental Health

PROCEDURES:

I. Applicability of Death Review Procedures:

A. In order to most efficiently use the resources of the State of Nevada, review activities are adjusted according to the circumstances of the death and the extent of services the person was receiving.

B. Any incident in which the person who died was currently receiving 24 hour services from a Division mental health agency, death or unanticipated death occurring within 48 hours of discharge or a suicide occurring within 72 hours of discharge from such a setting is subject to Policy CRR-1.13 Sentinel Events.

C. Incidents of individuals currently receiving community based services who commit suicide will be analyzed using a root cause analysis type process.

D. Former consumers closed to services more than 30 days prior to death are not required to be reported.

E. Consumers who die accidentally, by natural causes or from disease process unrelated to their mental illness (causes other than suicide) will be reported as a Division serious incident but the root cause analysis is not necessary.

II. Receipt of notification of death:

A. Within one business day of receipt of notification of a death, the Agency Director or designee will secure and/or direct to be secured the consumers' complete,

original clinical records including relevant records from contracted residential facilities to the custody of the Director of Health Information Services or applicable staff designated by the Agency Director.

B. A serious Incident Report (SIR) will be completed, per Division Policy #CRR-1.4 Reporting of Serious Incidents. The following information will be included in the SIR:

1. What is the reported time, date and reported/apparent cause of death? Note if the coroner was contacted.
2. Where was the consumer found?
3. Who found the consumer?
4. Was there a history of suicide or assaultive symptoms? Give analysis of care specific to suicide or assaultive symptomatology for the last six months.
5. If the consumer missed appointments during the past six months, was appropriate follow-up done?
6. Give a summary of the consumer's contact with the Agency with special emphasis to services provided within the last six months.
7. Were any medical conditions present? If so, describe contacts with the medical provider during the last six months of care relative to the condition.
8. Describe interaction between Division programs and all non-Division community based programs for the past six months.
9. Was grief counseling offered to the family? If not, give reasons.
10. Is the Agency PI Director referring this death for root cause analysis?
11. Is the Agency Director referring this death for a root cause analysis?
12. Is the Medical Director referring this death for root cause analysis?

III. Root Cause Analysis Team (RCA) – Structure:

A. RCA Team is not comprised of standing committee members; rather the membership is flexible based on the expertise required by the circumstances of each case. This also allows the agency to develop depth in the skills required to conduct such analysis.

B. Each Agency Director shall appoint a facilitator for each RCA Team. The facilitator must be someone who has received training on the root cause analysis process. The facilitator's responsibilities include but are not limited to the following.

1. Facilitate the root cause analysis process.
2. Ensure the collection of all necessary materials (i.e., medical records, policies, equipment).

3. Provide involved staff with information on the root cause analysis process and generally prepare team for the process.

4. Ensure that a report on each review is sent to the Deputy Administrator of Clinical Services and the Statewide Medical Director.

C. The Director of Health Information Services or appropriate staff of the Division agency, from which the consumer was receiving services, will serve as technical consultant in reviewing the clinical record for completion and adherence to agency standards regarding records. If an analysis is determined to be necessary, the Director of Health Information Services or appropriate staff will request a copy of Coroner's report and toxicology report. Upon receipt these reports will become a part of the permanent medical record.

D. The Director of Performance Improvement for each Division agency from which the consumer was receiving services, shall be a consultant to the team for specific policy, procedure, external standards and PI monitoring features.

E. A Pharmacist will be appointed by the Agency Director to consult with the Death Analysis Team. Agencies that do not have a staff pharmacist may request assistance from an agency that does by making such a request to the Statewide Pharmacy Director.

F. The remainder of the team will consist of at least three members of the staff representative of the positions involved in the treatment of the person including a physician.

IV. Root Cause Analysis (RCA) Team – Procedure:

A. Deaths suspected to be a suicide as determined by the Agency Director or Medical Director are to be referred to a RCA team. Other circumstances may be referred to a RCA team at the discretion of the Agency Director and the Medical Director.

B. The team is to be convened within six weeks, unless the event is deemed a sentinel event.

C. The review will be conducted as a root cause analysis. The purpose of the review is to establish any system improvements that will reduce risk of future similar outcomes. The review should include the following steps:

1. Event investigation;
2. Event reconstruction and analysis;
3. Review of the chart review and recommendation stemming from it;

4. Identification of root causes and contributing factors;
5. Development of action plan; and
6. Report of findings.

V. Root Cause Analysis (RCA) Team – Report:

A. The report is to be sent to the Agency Director, Deputy Administrator of Clinical Services and Statewide Medical Director. The report must include the following:

1. Factual narrative of the event
2. Description of the investigation and analysis process
3. Factors contributing to the event
4. Findings
5. Action Plan

B. The report should de-identify individuals using only coded labels (i.e. nurse1, tech2, etc.)

C. The report is to be delivered to the Agency Director, Division Deputy Administrator of Clinical Services and Statewide Medical Director no more than 30 days after the RCA team received the referral for review.

VI. Root Cause Analysis Team – Follow Up and Closure:

A. The Agency Director is responsible for ensuring the initiation and tracking of the action plan, when applicable.

B. The Agency Director is responsible for submitting a follow-up SIR within 10 business days of receiving report. This follow up to the original SIR should include any activities completed by the agency and shall determine effectiveness and may submit a request to the Deputy Administrator for review and closure.

C. Upon implementation of all action plans, the Agency Director submit a request to the Deputy Administrator of Clinical Services for review and closure.

D. The Root Cause Analysis process shall be completed within 6 months of the receipt of the report of death, however, additional time may be granted in extenuating circumstances. All activity related to death to include Root Cause Analysis, development and, implementation of action plan, determination of effectiveness shall be completed within 6 months and may submit request for review and closure to Deputy Administrator of Clinical Services.

E. The Deputy Administrator of Clinical Services will close the incidents.

F. Agency Director will ensure that all action plans are completed and the results of such plans are reported to Agency and Division Leadership and The Executive Committee of the Medical Staff, when applicable.

VII. Completed analyses may be referred for review to the Commission on Mental Health and Developmental Services by the Deputy Administrator of Clinical Services.

VIII. The review, report and action provided pursuant to this policy is a performance improvement function of the Division agencies, undertaken to help assure appropriate quality services to Division consumers. As such, the performance improvement privilege attached to the actions of the RCA team, Clinical Supervisors, Agency Directors, and Division Administrators, all documents, notes, conversations or discussions by the committee reviewed or made in the course of its exercise of its function are privileged and not subject to disclosure.

B. Performance Improvement: Review of Consumers Death for Developmental Services Agencies

POLICY: It is the policy of the Division to review certain cases in which people receiving services from Regional Centers die. Following internal review by the Division, these cases will be presented to the Mental Health Commission prior to final closure.

PURPOSE: The purpose of the review is to assess the services provided and make recommendations for improvements in policy, procedures, and agency practices in order to reduce risk, improve quality of supports, and maximize the health and safety of people receiving services. Recommendations stemming from these reviews will be used to promote quality services at all Division agencies.

SCOPE: Division wide – Developmental Services

PROCEDURES:

I. Applicability of Death Review Procedures:

A. In order to most efficiently use the resources of the State of Nevada, review activities are adjusted according to the circumstances of the death and the extent of services the person was receiving.

B. Incidents in which a person dies in unanticipated circumstances that are unclear will be analyzed by a Death Analysis team.

C. Individuals receiving community-based services who die accidentally, by natural causes or from disease process will be reviewed by the Quality Assurance Specialist III or other designated staff and referred to the more extensive death analysis process only if deemed necessary by the agency QAS III, Agency Director, State Medical Director, or Division Administration.

II. Immediate action upon receipt of notification of death:

A. Within one business day of receipt of notification of a death, the Agency Director or designee will direct the person's record, including electronic notes, to be secured or locked. The person's complete, original records, including all confidential QA documents, will be placed in the custody of the Quality Assurance Specialist III or applicable staff designated by the agency Director.

B. Records relevant to death held by contract providers will be secured within one (1) working day of notification of a death and help secure pending closure of review. The Service Coordinator, Program Coordinator, or designee will bring all provider records to the nearest office of the agency and deliver those records to the agency QAS III or applicable staff designated by the Agency Director in the most efficient and secure manner possible.

C. The service coordinator or program coordinator will complete a Serious Incident Report (SIR) per Division Policy #CRR-1.4 Reporting of Serious Incidents. The following information will be included in the SIR:

1. Where was the person when the death occurred?
2. What were the circumstances surrounding the person's death?
3. What was the time and date of death?
4. Describe the nature of the person's disabilities.
5. Description of all services being provided to the person through the regional center. Include information about the length of time each service was in place and history of regional center services.
6. Information about any providers who were contracted for services.
7. Describe relevant medical and/or behavioral history.
8. Describe the type(s) and frequency of contacts from the service coordinator or other regional center staff.
9. Was there a history of dangerous behaviors? If so, describe the behaviors in the past 6 months.

III. If a determination is made, the person's Service Coordinator or Program Coordinator will request that a copy of the Death Certificate, Coroner's Report, and Toxicology Screen, as available, be forwarded directly to them or other designee. Once obtained, these documents shall become part of the person's record.

IV. If the person lives in an ICF/MR facility, the Residential Director or designee will notify the Bureau of Healthcare Quality and Compliance of the person's death.

V. Death Analysis Team – Structure:

A. Membership of the Death Analysis Team is flexible based on the expertise required by the circumstances of each case.

B. The Agency Director shall appoint a facilitator to the Death Analysis Team. The facilitator must be someone who has training in the root cause analysis process. The facilitator's responsibilities include, but are not limited to the following:

1. Ensure the collection of all necessary materials and documentation (notes, policies, reports, service logs, assessments and so forth);

2. Facilitate the process of analysis for involved staff;

3. Ensure a report on each review is sent to the Agency Director and Medical Director.

C. The Agency QAS III shall be a consultant to the team for specific policy, external standards, and monitoring features.

D. The rest of the committee will consist of at least three members of the staff representing the positions involved in providing services for the person, including the Regional Center and its contractors. An Agency RN may be involved when the death involved a medical condition or disease process.

VI. Death Analysis Team – Procedures:

A. Deaths are referred for analysis to the Death Analysis Team at the discretion of the Agency Director or designee.

B. The team is to be convened within six weeks of receipt of the report of death, unless determined to be a Sentinel Event. Additional time may be granted in the event that relevant information (i.e. coroner's report) is not yet available.

C. The purpose of the analysis is to establish any system improvements that will reduce risk of future similar outcomes. The review team shall identify contributing factors and address the following issues , as applicable, in their proceedings and report:

D. The Death Analysis Team shall summarize their findings and recommendations in a final written report that shall be sent to the Agency Director. The Agency Director shall forward the report to the Division of MHDS and the Statewide Medical Director for their review and recommendations.

1. What was the cause and circumstances of the person's death according to the Coroner or death certificate?
2. Where did the person live?
3. Was the person's ISP current and reflective of the person's goals, wishes, and service requests?
4. Did the ISP identify any risks to health and safety for the person? If so, describe them.
5. What support services were being provided to the person prior to the person's death?
6. What was the person's health status? Describe any medical interventions or hospitalizations within the past year.
7. What medication did the person take? Describe the purpose for each medication (e.g., diagnosis, behavior, or medical condition).

8. Was the person receiving recommended medical or behavioral health services prior to death? If not, describe the efforts made by the Regional Center to assist the person to access needed services or supports.
9. List the attending physicians and other professionals providing medical and behavioral health care and the date last seen.
10. Was the person and guardian, if applicable, willing to accept services as recommended by the individual's support team? If not, what steps were taken by the Regional Center to assist and support the person?
11. If the person received residential supports, what was the extent of those supports (e.g., hours of service, staffing ratios)?
    a. Describe any specialized needs for support for the person.
    b. What qualifications did the direct support staff have (e.g., training, specialized knowledge) related to the person's needs?
    c. Were supports adequate to meet the person's need? If not, why not?
12. Did the person have adequate safety skills? If not, what supports did the person receive (supervision, instruction) to maintain personal safety?
13. If the person had any due process reviews by relevant committees (e.g., Behavior Intervention or Human Rights Review Committee), what were the results and recommendations from the last reported review?
14. Were the supports provided adequate to promote health and safety? What could have been done differently to improve the person's health and safety status?

E. The Death Analysis Team shall summarize their findings and recommendations in a final written report that shall be sent to the Agency Director. The Agency Director shall forward the report to the Division of MHDS and the Statewide Medical Director for their review and recommendations.

VII. The Agency Director shall request the closure of a SIR and Deputy Director will close the SIR.

VIII. Death Analysis Team – Report

A. The report is to be sent to the Agency Director and the Statewide Medical Director. The report must include the following:

1. Factual narrative of the event

2. Description of the investigation process
3. Findings
4. Action plan

B. The report should de-identify individuals using only coded labors (i.e., staff1, staff2, SC).

C. The report is to be delivered to the Agency Director and the Statewide Medical Director no more than six weeks after the team received the referral for review. If the death certificate has not yet been received and the team decides this information is required to complete the report, an initial report will be filed and the final report completed and delivered within two weeks of receipt of the certificate which states the cause of death.

XI. Death Analysis Team – Follow Up and Closure:

A. The Agency Director is responsible for ensuring the initiation and tracking of the action plan.

B. Agency Director is responsible for submitting a follow-up SIR within 10 business days of receiving the report. This follow-up to the original SIR should include any activities completed by the agency and shall determine effectiveness and may submit a request to the Deputy Administrator for review and closure.

C. Upon implementation of all action plans, the Agency Director may submit a request to Deputy Administrator for review and closure.

D. The Death Review process should be completed within 6 months of the receipt of the report of death, however, additional time may be granted in extenuating circumstances. All activity related to death to include Root Cause Analysis, development and, implementation of action plan, determination of effectiveness shall be completed within 6 months and may submit request for review and closure to Deputy Administrator of Clinical Services

E. The Deputy Administrator shall close the SIR.

The Root Cause Analysis process should be completed within 6 months of the receipt of the report of death, however, additional time may be granted in extenuating circumstances.

X. Completed analyses may be referred for review to the Commission on Mental Health and Developmental Services by the Deputy Administrator.

XI. The review, report and action provided pursuant to this policy is a performance improvement function of the Division agencies, undertaken to help assure appropriate quality services to Division consumers. As such, the performance improvement privilege attached to the actions of the committee, Clinical Supervisors, Agency Directors, and Division Administrators, all documents, notes, conversations or discussions by the committee reviewed or made in the course of its exercise of its function are privileged and not subject to disclosure.

ADMINISTRATOR

EFFECTIVE DATE: 12/31/97
REVISED/REVIEW DATE: 11/27/02, 1/28/03, 7/7/03, 11/18/03, 5/28/07, 11/19/10, 3/15/2013
SUPERSEDES: POLICY #: 4.019 Performance Improvement Review of Consumer (Client) Death
APPROVED BY MHDS ADMINISTRATOR: 4/16/10, 11/19/10, 3/15/2013
APPROVED BY MHDS COMMISSION: 5/20/10, 11/19/10, 3/15/2013