Quality Improvement from the Mortality Review Process

Extending Beyond the Deceased to Manage Risk

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Objectives

☐ An understanding of the components for a mortality review put forth by the U.S. Government Accountability Office (GAO).

☐ Review of a comprehensive mortality review process that meets all 10 components outlined by the GAO.

☐ Examination of a risk management process that has grown out of the presented mortality review process.
  • Anyone else at risk initiative
  • Newsletters and other communications
CMS Should Encourage States to Conduct Mortality Reviews for Individuals with Developmental Disabilities

U.S. Government Accountability Office (GAO) Medicaid Home and Community-Based Waivers

(http://www.gao.gov/new.items/d08529.pdf)
Components of Mortality Reviews  (GAO Report)

6 Basic (B)
1. Screen individual deaths with standard information.
2. Review unexpected deaths, at a minimum.
3. Routinely include medical professionals in mortality reviews.
4. Document mortality review process, findings, or recommendations.
5. Use mortality information to address quality of care.
6. Aggregate mortality data over time to identify trends.

4 Additional (A)
1. Use a statewide interdisciplinary mortality review committee (e.g., overseen by developmental disabilities agency).
2. Routinely include external stakeholders in review process (e.g., protection and advocacy agency).
3. Take statewide action based on mortality information to systemically improve care.
Screening Process (B1)

- Implemented a multi-layered screening process to determine:
  - If a further review of housemates (when applicable) is warranted
  - If the death requires an expedited review
  - Developed guideline: ‘Categorization of Death’

Sample Expedited Review Criteria
- Transition from SODC within 12 months
- Trauma
- Aspiration/choking
- Pneumonia
- Sepsis
- Sudden Death
Review of Unexpected Deaths (B2)

Reportable Deaths

- Death of any individual with I/DD that received services through the Bureau of Developmental Disabilities Services (BDDS).
- Various settings include family homes if receiving waiver services, waiver homes, supported group living (SGL) homes, large private intermediate care facilities (LP-ICF/I/DD), nursing homes, etc.
- Deaths are reported regardless of whether staff was on duty at the time of death.
- Deaths are reported regardless of whether there was a terminal illness, the person was elderly, or death was expected.

Review

- Have a process for categorization of death.
- All deaths are reviewed for cause and circumstances.
Routinely Include Medical Professionals in Mortality Review (B3)

Mortality Review Triage Team (MRTT)
- Mortality Review Physician
  - A board certified physician with experience working with the I/DD population
- Mortality Investigator
- Mortality Review Intake Coordinator
- Incident and Mortality Review Director

Mortality Review Committee (MRC)
- Mortality Review Physician
- A registered nurse from the Department of Health
- Representative from Adult Protective Services (APS)
- Representative from the Coroners Association
- Representatives from community advocate groups
- Legal representative
- State representatives
Intake and Classification

Request for Documents
- The same information is routinely submitted for each death.
- The avenue by which the documents are submitted and the pertinent timeframes for submission vary depending on whether the death met the criteria for an expedited review.

Review and Investigation

MRTT

MRC

Meeting minutes and MRC recommendations are forwarded to the state for review and approval.
Use Mortality Information to Address Quality of Care (B5)

- Review through MRTT and MRC result in recommendation for quality improvement.
  - Provider Level – Through follow-up and review to determine if anyone else is at risk.
  - Systemic Level – Through aggregation of data, analysis and communication to stakeholders.

- Anyone Else At Risk Initiative.
Anyone Else at Risk Initiative

- Goes beyond narrow focus of death.
- Includes review of quality of care and safety.
- Reviews concerns not directly contributing to death.
- Reviews concerns that could apply to health and safety of others (lack of current risk plans, delayed staff training, inconsistencies in documents, etc.).
Anyone Else at Risk Initiative

- Focus on review of submitted incident reports for housemates to determine if similar problems such as medication errors, falls, etc.

- Review of similar diagnoses or treatments among housemates (if death of individual with dysphagia, feeding tube, or specific diet texture or liquid thickening, do other housemates have similar risks or diets?).

- A challenge of the initial review – information limited to the contents of the submitted incident reports.
Anyone Else:
Sample of Additional Information Requested

☐ MARs from 2 months prior to death.
☐ Copy of CPR cards for staff who worked in the home during the 30 days prior to death.
☐ Clarification on how medications were presented to the individual (in applesauce, pudding, with thickened liquids, etc.) due to inconsistencies in documents.
☐ Daily staff notes on the date of death.
☐ Policy/procedure/protocol for responding to emergency situations.
☐ Copy of individual’s bowel management log.
☐ Copy of Restrictive Procedures Plan referenced in BSP.
Anyone Else at Risk Initiative

☐ At times, due to concerns of completeness/accuracy of various databases, request verification of housemates from the provider agency.

☐ Look for trends through review of incident reports.

☐ Review number of deaths/causes of death for that provider agency in the district (a geographical area of the state) for the previous 365 days (all deaths other than those from a LP-ICF/IDD or nursing home).

☐ Determine number of individuals served by that provider agency in the district.
Anyone Else at Risk Initiative

- Includes a review of proximity of provider agency homes.
- Focus on staffing shared among homes.
- Incident reports/deaths in other homes.
- Initiate on-site survey/review for sampling of individuals in other homes with the provider agency.
Anyone Else: Impact of Process

- Data from the initial Anyone Else at Risk meeting (data for June 2012 through March 2014)
  - Number of death of person incident reports received: 387 (all deaths except LP-ICF and nursing home)
  - Number of deaths where concerns were identified: 40
  - Number of further reviews by MRTT: 19
  - Number of referrals to DoH: 11
  - Number of referrals to BQIS: 9
  - Number of referrals to BQIS and DoH: 1
  - Percentage of deaths resulting in referral: 10.34%
Aggregate Mortality Data Over Time to Identify Trends (B6)

☐ Have data for 2206 deaths during the time period of 10/1/08-3/31/14.

☐ Reviewed specific common causes of death:
  - Sepsis
  - Cardiovascular disease
  - Respiratory disease (noninfectious)
  - Cancer

☐ These 4 causes contributed to 52% of all deaths.

<table>
<thead>
<tr>
<th>Decade</th>
<th>Total Deaths</th>
<th>Cardio-vascular</th>
<th>Respiratory</th>
<th>Cancer</th>
<th>Sepsis</th>
</tr>
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<tbody>
<tr>
<td>&lt;30</td>
<td>181</td>
<td>20</td>
<td>44</td>
<td>6</td>
<td>15</td>
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<tr>
<td>30s</td>
<td>154</td>
<td>24</td>
<td>21</td>
<td>12</td>
<td>12</td>
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<tr>
<td>40s</td>
<td>231</td>
<td>41</td>
<td>33</td>
<td>19</td>
<td>19</td>
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<tr>
<td>50s</td>
<td>485</td>
<td>89</td>
<td>60</td>
<td>60</td>
<td>50</td>
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<tr>
<td>60s</td>
<td>543</td>
<td>103</td>
<td>82</td>
<td>56</td>
<td>56</td>
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<tr>
<td>70s</td>
<td>367</td>
<td>86</td>
<td>37</td>
<td>34</td>
<td>35</td>
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<tr>
<td>80s</td>
<td>209</td>
<td>52</td>
<td>22</td>
<td>25</td>
<td>13</td>
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<tr>
<td>90+</td>
<td>36</td>
<td>6</td>
<td>2</td>
<td>2</td>
<td>2</td>
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<tr>
<td>Total</td>
<td>2206</td>
<td>421</td>
<td>301</td>
<td>214</td>
<td>202</td>
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</table>
Use a Statewide Interdisciplinary Mortality Review Committee (A1)

(e.g., Overseen by developmental disabilities agency)

MRC Membership includes representatives from:

- Bureau of Developmental Disabilities Services
- Bureau of Quality Improvement Services
- Office of Medicaid Policy and Planning
- Office of General Counsel
- Developmental Disability Ombudsman
Routinely Include External Stakeholders in Review Process (A2)

(e.g., protection and advocacy program)

External membership of MRC includes representatives from:

- Family member of person(s) with I/DD
- Community advocates for I/DD population
- Adult Protective Services (APS)
- Coroner
Take Statewide Action Based in Mortality Information to Systematically Improve Care (A3)

- Used when requesting follow-up reports for incidents.
- Used as an aid when developing a comprehensive quality risk plan.
- Development of specific checklists for risk areas.
  - Checklists developed to date:
    - Choking/acute aspiration
    - Fractures (regardless of cause – fall, aggression, SIB, etc.)
    - Feeding tube displacements
    - Pressure ulcers
# Choking Checklist

**Instructions:** Please review the attached checklist regarding specific questions related to the reported choking incident for this person. Please include the answers to all of the questions.

## GENERAL QUESTIONS

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What was the item the person choked on? If not known, then what was the last item he/she ate?</td>
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<tr>
<td>2. Where was the person at the time of the incident (e.g., dining table, couch, bed, etc.)</td>
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<tr>
<td>3. Was there a dining/choking risk plan in place prior to the choking incident? If so, was the plan being followed?</td>
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<td>4. Have there been any previous choking episodes? If so, when?</td>
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<td>5. Does the person have difficulty chewing or swallowing?</td>
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<td>6. Does the person have a specialized diet texture/fluid consistency ordered (pureed, chopped, thickened liquids, etc.)?</td>
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<td>7. Does the person have a positioning plan during mealtimes? If so, was the plan followed at the time of the incident?</td>
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<tr>
<td>8. What is the person’s level of supervision during meals (and snacks)?</td>
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<tr>
<td>9. If the person was new to the home within the past 6 months, was all relevant dining information communicated at transition? Were the receiving staff trained to competency?</td>
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<tr>
<td>10. What immediate safety measures are in place to ensure there is not another choking episode until the team can convene to formalize a next step?</td>
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<tr>
<td>11. What is the outcome of the team’s evaluation/assessment of the incident? Were any changes made to the person’s dining/choking risk plan?</td>
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</tbody>
</table>

## UNSAFE EATING ISSUES

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
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<tbody>
<tr>
<td>12. Does the person engage in unsafe eating habits (rapid rate of eating, stuffing mouth, taking large bites, pica, etc.)?</td>
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<td>13. Was there food within reach if this is a risk for the person?</td>
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<td>14. Does the person have formal dining objectives in place to address the unsafe eating habit(s)?</td>
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<td>15. Is the person on medications known to increase appetite?</td>
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<tr>
<td>16. If the person has food-stealing behaviors, does he/she have increased supervision and/or decreased access to food?</td>
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</table>

## STAFFING ISSUES/STAFF TRAINING ISSUES

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>17. Were staff following the required level of supervision/monitoring (including required proximity to the person) during the incident?</td>
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<tr>
<td>18. How long had the staff on duty during the choking incident been working with the person (e.g., years, months, weeks, days, etc)?</td>
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<tr>
<td>19. Was the staff working overtime when the incident occurred?</td>
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<tr>
<td>20. Was staff trained in emergency intervention, including CPR and Heimlich? Was the staff’s certification current at the time of the incident? Please provide the expiration date for each staff present at the time of the incident along with a copy of the staff log/sign in sheet for that shift</td>
<td></td>
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<tr>
<td>21. Are all staff, in all settings, trained to competency for specific details of the dining/choking risk plan, including specifics on how to cut-up food, what size of pieces are appropriate, how food is to be presented (e.g., plate to plate), correct consistency of food/liquids, etc.?</td>
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## ENVIRONMENTAL ISSUES TO CONSIDER

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
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<tbody>
<tr>
<td>22. Are there specific instructions for staff to follow regarding their proximity during meals (e.g., sitting at the right side of the person, is the person at a table close to staff)? Review location during all meals - e.g., workshop, home, dining out, etc.)</td>
<td></td>
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<tr>
<td>23. How are food items secured in cases of risk (without restricting anyone’s rights and appropriate access to food items)?</td>
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<tr>
<td>24. Were there distractions in the environment when the incident occurred (chaotic/noisy environment, unfamiliar people in the area, staff talking/texting on cell phone etc.)?</td>
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</table>
### Choking Checklist (cont.)

#### AFTER THE INCIDENT
- **25.** Was the person taken to the ER/hospital? If hospitalized, how many days of hospitalization? What was the final diagnosis at time of discharge?
- **26.** Was a dysphagia evaluation completed by a speech therapist as a result of the choking incident?
- **27.** Was a swallow study recommended? If so, was it completed? Have the recommendations been implemented?

#### MONITORING BY STAFF
- **28.** Was the person observed for signs and symptoms of aspiration for 3-5 days after the incident?
- **29.** Did the person display any signs and symptoms of aspiration? Includes: elevated temperature, cough, lethargy, refusal of meals, chest congestion, pale grey-blue skin, difficulty breathing, decreased food/fluid intake, change in sleeping habits.

#### MONITORING BY MANAGEMENT
- **30.** How does the team identify triggers for dysphagia, choking, aspiration?
- **31.** How does the team ensure that the dining/choking risk plan is implemented consistently?
- **32.** Do various professionals and/or management staff monitor at mealtimes?
- **33.** Are there monitoring sheets in place? If so, were they in place before the incident?

#### REQUEST FOR DOCUMENTATION
- **34.** Copy of person’s previous dining/choking risk plan
- **35.** Copy of person’s updated dining/choking risk plan
- **36.** Information (including any relevant documents) regarding whether the person displayed any signs/symptoms of aspiration for 3-5 days following the incident. ***If written documentation was not completed, this should be acknowledged***
- **37.** Copy of a choking assessment completed by the team with monitoring frequency determined by level of choking risk (the higher the risk the more frequent the monitoring required)
- **38.** Staff training records regarding the dining/choking risk plan (ALL settings - home and day programs)

**Note:** Training should be competency-based (hands-on implementation of procedures to ensure staff understand and can perform)

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| Name | Date of Choking Incident | Time of Choking Incident | ER # |
# Fracture Checklist

**Incident Resulting in a Fracture Checklist**

**Proactive Risk Management:** If a person receiving services/supports has this identified risk factor, this checklist can be utilized when developing and/or reviewing/revising a risk plan.

**Educational Tool:** Training curriculum, both general and individual-specific, can incorporate the information on this checklist.

**Addressing Specific Incidents:** As an incident occurs, the team can work through the variables that could have been contributing factors and ensure appropriate actions are taken to reduce the likelihood of a future incident of a similar manner.

<table>
<thead>
<tr>
<th>Issue</th>
<th>#</th>
<th>GENERAL QUESTIONS</th>
</tr>
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<tbody>
<tr>
<td></td>
<td></td>
<td><strong>WAS THERE A FALL?</strong></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>Was there a prior fall (with or without injury) in the past six months?</td>
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<td>2</td>
<td>Does the person have a known “fear of falling”?</td>
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<td>3</td>
<td>What was the activity at the time of the fall?</td>
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<td>What was the location of the fall (e.g., kitchen, bathroom, sidewalk, etc.)?</td>
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<td>5</td>
<td>What type of surface did the person land on?</td>
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<td>6</td>
<td>If from a height, how far did the person fall?</td>
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<td>7</td>
<td>If the fall occurred outside, what was the temperature and weather conditions at the time?</td>
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<td>8</td>
<td>Was there a use of restraint at the time of the fall? If so, what kind?</td>
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<td>9</td>
<td>Was there a challenging behavior exhibited at the time of the fall?</td>
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<td>10</td>
<td>If #9 is yes, what was the staff’s response to reduce the behavior prior to the fall?</td>
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<td>11</td>
<td>If #9 is yes, was there a behavior support plan?</td>
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<td>12</td>
<td>Were there any signs of illness/unsteadiness prior to the fall?</td>
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<td>13</td>
<td>Was the fall associated with a new onset of a medical problem?</td>
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<td>14</td>
<td>Does the person have a known medical problem which contributes to falls?</td>
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<td>15</td>
<td>Does the person use assistive devices for ambulation?</td>
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<td>16</td>
<td>Were there any recent medication changes (e.g., new medications, change in dosage of old medications, new over-the-counter medications, etc.)?</td>
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<td></td>
<td>17</td>
<td>Did the environment contribute to the fall (e.g., poor lighting, loose rugs, cords on the floor, worn footwear, shoelaces, glare, slippery floors, etc.)?</td>
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<td></td>
<td>18</td>
<td>How has the team addressed preventing another fall?</td>
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<td>19</td>
<td>Was an updated fall risk assessment completed after the fall?</td>
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<td>20</td>
<td>Was there use of preventive health programs (e.g., exercise program, strengthening, PT, OT, home evaluation by OT, personal emergency response system (PERS), etc.)?</td>
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<td>21</td>
<td>Was there a recommendation for an assistive device?</td>
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<td>22</td>
<td>Have any other changes been implemented (e.g., footwear, environmental improvements, etc.)?</td>
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<tr>
<td></td>
<td>22.1</td>
<td>Was a fall prevention plan in place prior to the incident? If so, was the plan being followed at the time of the incident?</td>
</tr>
</tbody>
</table>
### Fracture Checklist (cont.)

#### 23 IF THE PERSON DID NOT FALL, WHAT CAUSED THE FRACTURE?
- a. Altercation with a peer?
- b. Altercation with a nonpeer?
- c. Bumping into something/Crushing injury?
- d. Motor vehicle accident/bicycle/pedestrian accident?
- e. Sports activity or other leisure activity?
- f. Pathological cause (e.g., osteoporosis, bone cyst, etc.) as determined by physician?
- g. Undetermined, but probable fall
- h. Undetermined, but probably not due to a fall

#### AFTER THE INCIDENT
- 24 Were there other injuries at the time of the fracture?
- 25 Was the person seen in the ER or hospitalized? If hospitalized, how many days of hospitalization?
- 26 What changes have been made to the risk plan to prevent further fractures?
- 27 What type of fracture occurred (e.g., displaced/nondisplaced, simple/compound, stress, other, etc.)?
- 28 What treatment was provided?

#### STAFFING ISSUES/STAFF TRAINING ISSUES

- Note: Training should be competency-based (hands-on implementation of procedures to ensure staff understand and can perform)
- 29 Were staff following the required level of supervision/monitoring (including required proximity to the person) during the incident?

- 30 How long had the staff on duty been working with the person (e.g., years, months, weeks, days, etc.)?
- 31 Are all staff in all settings trained to competency on specific details of the fall/fracture prevention plan?

#### MONITORING BY MANAGEMENT
- 32 How does the team ensure that the fall/fracture prevention plan is implemented consistently?

#### PERTINENT DOCUMENTATION
- 33 Copy of person’s previous fall/fracture prevention plan
- 34 Copy of person’s updated fall/fracture prevention plan
- 35 Copy of a fall assessment completed by the team
- 36 Copy of a fracture risk assessment completed by the team
- 37 Staff training records regarding the fall/fracture prevention plan (ALL settings - home and day programs)

Note: Training should be competency-based (hands-on implementation of procedures to ensure staff understand and can perform)

<table>
<thead>
<tr>
<th>Name</th>
<th>Date</th>
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Publically Report Mortality Information (A4)

- Periodic/quarterly communications available on the website of the QI I/DD agency.

- A wide range of topics covered based on MRTT and MRC reviews (may be topics associated with either morbidity or mortality) (not limited to):
  - Recognizing and responding to changes in health status.
  - Requirement for current CPR certification.
  - Indications for risk plans.
  - Timely staff training and documentation of same regarding risk plans.
  - Monitoring effectiveness of risk plans.
  - Diet textures (e.g., definitions, examples, importance of providing prescribed textures).
  - Documentation standards in progress notes/daily notes that require documentation of consistency of liquids and texture of foods when a meal or snack is served.
Example of MRTT Communication with Provider Agency

- "UTI protocol states ‘drink plenty of liquids.’ Individual is NPO. This fact is not included on the protocol. If someone read and followed this protocol, the individual would be at risk. Recommendation: update the UTI protocol so it reflects NPO status.

- The diet in the Risk Management and Assessment Plan (RMAP) states that diet is ‘a mechanical #2 soft with ground meat and supervised by staff at table while eating.’ If someone read and followed this plan, individual would be at risk. Recommendation: update the RMAP so it reflects NPO status."
Example of MRTT Communication with Provider Agency

☐ The RMAP states ‘fingerless biker gloves which are worn when hand-biting activity occurs during the day. Are to be off at night at all times.’ is this technique approved by the HRC? Recommendation: If HRC has not reviewed the plan, they should review and approve/disapprove. If HRC has approved, might be prudent to include that statement in the RMAP.

☐ The medications listed on the MAR do not clearly identify the correct route (via G tube). Some medications still state medication is given by mouth/po. Recommendation: review and update all medications to include the correct route for administering medications. It is also suggested that this QA step be implemented systemically (ensure the correct route on the MARs for everyone receiving services).
Mortality Communications

Bureau of Quality Improvement Services (BQIS)

Mortality Communication

Mortality Communication Purpose

- On a quarterly basis BQIS produces communications summarizing incident data, mortality data, and findings from complaint investigations and provider compliance reviews. Every issue presented in these communications is supported by data indicating the need for improvement. BQIS expects that providers will review this information, assess how the agency can best address the identified issues with their consumers and staff, and incorporate these new practices into its systems.
- The following issues were identified during mortality reviews completed during the second quarter of fiscal year 2013 (October through December 2012).
- While the data presented may pertain to comorbid conditions that are not attributable to the cause of death, the risk involved with these conditions warrant further examination.
- This communication is not intended to provide specific medical recommendations and interested parties should seek further clarification from trained medical professionals.

As mortality reviews are conducted, there continue to be times when concerns are identified in this area. Based on cases reviewed this quarter, the following issues were noted at least once and determined to be issues that would be beneficial to share with providers and other interested stakeholders in order to review, share with pertinent team members, and take proactive steps as appropriate.

Fluid Tracking

As mortality reviews are conducted, there continue to be times when concerns are identified in this area. Based on cases reviewed this quarter, the following issues were noted at least once and determined to be issues that would be beneficial to share with providers and other interested stakeholders in order to review, share with pertinent team members, and take proactive steps as appropriate.
Thank You
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