GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT ON DISABILITY SERVICES

PROCEDURE	
Subject: Mortality Reporting Procedure	Procedure No.: 2013-DDS-QMD-PR010 (Rev)
Responsible Program or Office: Quality Management Division	Date Approved: July 12, 2013
Number of Pages: 7	Effective Date: July 15, 2013
Cross References, Related Policies and Procedures, and Related Documents: Mortality Review policy, Mortality Review Committee Procedure, Incident Management Enforcement Unit policy and procedures, Duty Officer policy and procedure, Immediate Response Committee policy and procedure, Imposition of Provider Sanctions policy, Enhanced Monitoring procedure, Watch List procedure, Imposition of Adaptive Equipment Sanctions procedure, Mortality Notification Form, Safety Assessment	

All underlined words/definitions can be found in the Definitions Appendix.

1. PURPOSE

The purpose of this procedure is to establish the standards and guidelines by which the Department on Disability Services ("DDS"), Developmental Disabilities Administration ("DDA"), will report and document the deaths of all people who receive supports and services from DDS/DDA, mitigate risk for other people served by the same provider, when indicated, and share information with the District of Columbia Office of the Chief Medical Examiner ("OCME").

2. APPLICABILITY

This policy applies to all DDA employees, subcontractors, providers/vendors, consultants, volunteers, and governmental agencies that provide services and supports on behalf of people with intellectual and developmental disabilities receiving services as part of the DDA Service Delivery System funded by DDA or the Department of Health Care Finance ("DHCF").

3. PROCEDURES

A. All Deaths

1. Reporting
   a. The provider shall report the death of any person who receives support from the provider to:

      i. The person's family.
      ii. The person's guardian, if he or she has one.
      iii. The person's advocate, if he or she has one.
      iv. The person's attorney, if he or she has one.
      v. Service Coordinator or DDA Duty Officer, in accordance with the DDS Incident Management Enforcement Unit ("IMEU") procedures for reporting Serious Reportable Incidents ("SRI").
         a. For deaths that occur during the business day, the provider either must speak with the person's service coordinator or enter the incident into MCIS by 5 p.m. that day. Entering the incident into MCIS will generate an automatic alert for the service coordinator. (If the provider chooses to call the person's Service Coordinator rather than enter the incident into MCIS immediately, the provider must still enter the incident into the MCIS Investigation and Reporting system by 5 p.m. the following business day).
         b. When there is a death that occurs during non-business hours, the provider must either immediately enter the incident into the MCIS Investigation and Reporting system, generating an automated alert for the Duty Officer; or must call the DDA Duty Officer at 202-498-9077 and speak directly with the Duty Officer. If the phone goes to the recorded message, the provider may leave a message but if the call is not returned within 30 minutes the provider must escalate the reporting to the Mayors Call Center. In the event that the Duty Officer is not reachable within 30 minutes, the provider must call 311 for the Mayor's Call Center who will take the initial report and contact the DDA Duty Officer. (If the provider chooses to call the Duty Officer rather than enter the incident into MCIS immediately, the provider must still enter the incident into the MCIS Investigation and Reporting system by 5 p.m. the following business day).
      vi. Office of the Chief Medical Examiner ("OCME").
      vii. Department of Health/Health Regulation and Licensing Administration ("DOH/HRLA") (in the event of deaths of people who receive supports in an Intermediate Care Facilities for Individuals with Intellectual and Development Disabilities ("ICFs/IDD") or District licensed Residential Habilitation homes).
      viii. Additionally, the provider shall notify the Metropolitan Police Department ("MPD") if a person who was receiving residential support dies suddenly and

unexpectedly at home or in the community. Notification to MPD is not otherwise required.

c. The Service Coordinator or Duty Officer shall notify the DDS Director, DDS Deputy Director for DDA, and the Directors of the Quality Management Division ("QMD") and Service Coordination and Planning Division and Health and Wellness, the Mortality Review Coordinator, and the Office of the General Counsel ("OGC") as soon as possible.

d. The Service Coordinator or Duty Officer shall also complete a summary of the circumstances surrounding the person's death (for example, using the attached "Mortality Notification Form") within one (1) business day.

e. The OGC will notify the Quality Trust for Individuals with Disabilities of all deaths; and the *Evans'* plaintiffs and *Evans'* Court Monitor when a person who is an *Evans* class member dies.

f. The Mortality Review Coordinator shall notify the Office of the Inspector General ("OIG") of all deaths; and DHCF (in the event of deaths of people who receive supports through the Medicaid Home and Community Based Services Waiver), within one (1) business day.

2. Investigation by OCME

a. The OCME must investigate all deaths of people supported by DDA. On the first business day following a person's death, the MRC Coordinator shall call the OCME and ensure that the assigned investigator has the person's current Health Care Passport, current Health Care Management Care Plan, the Mortality Notification Form and all Incident Reports that have been entered into MCIS. DDS will also notify the OCME of any findings it deems significant based on the review described in number 4. DDA Responsibilities. The OCME may also request additional records.

b. DDS will also notify the OCME in jurisdictions outside of the District of any findings it deems significant based on the review described in number 4. DDA Responsibilities. People who were supported by DDA who died outside of the District of Columbia, must have a signed death certificate from that jurisdiction before being transported across state lines back to D.C.

3. Provider Responsibilities

a. Each provider shall develop and implement procedures related to reporting deaths to DDA and associated processes, including staff members responsible for specific steps in the process.

b. The provider shall ensure the scene and all records are secured immediately upon notification of a death by its employees until such time as DDS or its agent collects or

releases the evidence. Provider responsibilities may include but are not limited to securing all relevant records, taking pictures of the scene, etc.

c. The provider shall ensure that DDS's contracted investigators and the DDS Mortality Review Coordinator, Duty Officer, Quality Management Division staff, and/ or Health and Wellness staff have full access to information that the investigator or staff deems reasonably necessary and appropriate in performing the investigation, including full access to witnesses to the incident, buildings, programs, documents, records and other materials. Advance notice of any visit is not required. Providers shall require their employees, contractors, consultants, volunteers, and interns cooperate with all investigators.

d. When DDS conducts a site visit, the provider shall have records available for review within an hour of DDS's request. At DDA's discretion, the DDS Mortality Review Coordinator, Duty Officer, Quality Management Division staff, and/ or Health and Wellness staff may take all or some of the person's record during a site visit. When this occurs, DDS shall copy the entire record, and then return the originals to the provider. The provider will then have 5 business days to make a copy the records, before it must return the originals to DDS.

e. If DDA does not conduct a site visit, within one (1) business day of DDS's request, the provider shall give DDS all of the physician's orders ("PO"), medication administration records ("MAR") for the past three months, most recent nursing assessment and any nursing notes since then; lab reports from the past three months, and staff progress notes from the last month. Within five (5) business days of DDS's request, the provider shall give DDS the complete Medical book, Individual Support Plan ("ISP") book, Program book, Staff Log notes, and all other pertinent documentation.

4. DDA Responsibilities

a. Upon notification of a death during regular business hours, within one (1) business day, the Health and Wellness Supervisory Community Health Nurse, or his or her designee, will review, at a minimum, the summary of the circumstances surrounding the person's death, the person's MCIS service coordination notes for the past three months, and incidents listed in MCIS for the past three months and will make a preliminary determination of whether or not the death was expected. For deaths that occur outside of regular business hours, the Duty Officer shall conduct this review.

b. Based on this review, during the same business day, the Health and Wellness Supervisory Community Health Nurse or Duty Officer, in consultation with the Quality Management Division Director, may also recommend further investigation to mitigate risk to other people supported by the provider, including but not limited to a medical desk review, site visit, safety assessment, and/ or safety review.

c. If systemic deficiencies are identified or suspected, the death investigation and/or the preliminary findings of the review may be referred expeditiously to the mortality and /or fatality committees. The QMD Director shall also consider the imposition of provider sanctions.

d. On the first business day following the completion of the incident report in MCIS by the Provider or SC, the incident report will be reviewed and accepted by the Immediate Response Committee ("IRC").

e. The Contract Administrator for the Independent Death Investigator will ensure notification to the Independent Death Investigator and assign the death for investigation.

B. Sudden and/or Unexpected Deaths ("SUD")

1. Immediate Actions:

a. The provider is responsible for immediately securing the health, safety, and wellbeing of other people they support, and also for securing the evidence, and the scene, if applicable, until released by DDS or its agent.

b. When notification or discovery of a SUD occurs during regular business hours, the QMD Director or his or her designee shall ensure that immediate notification is made to the police, if required, and that a preliminary investigation is conducted. The Duty Officer is responsible for notification to the police, if required, after regular business hours.

c. Safety Assessment

i. When notification or discovery of a SUD occurs during regular business hours, the QMD Director shall designate staff to conduct a safety assessment within eight (8) hours, to ensure the health, safety and well-being of the other people served in the same location or by the same staff. When notification occurs after hours, the Duty Officer shall conduct the safety assessment.

ii. As part of the safety assessment, the staff designated by the QMD Director or the Duty Officer shall conduct an on-site visit to ensure people are safe, and secure the environment, documents and records. (i.e., the physical site where the death occurred, equipment and/or items associated with the death). DDA Responsibilities on site may include, but are not limited to:

- DDA designee will take pictures when possible, not allow anyone to enter the room/area unless absolutely necessary, and will not disturb anything in the room or area.

- DDA designee will secure documents and records: All pertinent records should be copied or secured to prevent loss or tampering, including the person's records (nursing notes, medication administration records, and incident reports), house logs, and other pertinent facility documents.

- DDA designee will document a detailed description of events just prior to, during, and immediately following the event and include a copy with the secured documents.

d. Upon completion of the above, the QMD Director shall conduct a preliminary review of the circumstances and documentation of the death and shall determine whether further investigation to mitigate risk to other people supported by the provider is required, including but not limited to a medical desk review, additional site-visit, or safety review, discussed below.

2. A safety review includes:

   a. Assessing conditions at the location to determine if the safety of the other people who live there are threatened.

   b. Documenting and reporting the results to the DDS Deputy Director for DDA and the DDS Director.

   c. If issues identified are not immediately resolvable, the DDA designee conducting the safety assessment (e.g., through communication with community emergency personnel (911), DDA Deputy Director and/or Provider Administrator, or other appropriate managers) shall initiate acquisition of additional resources to resolve the concern. Example: District of Columbia's Protocol for Additional Enforcement Mechanisms for Providers Whose Performance Poses Potential Risk of Harm to *Evans* Class Members.

   d. An action plan shall be developed based on the findings to ensure all people who are served in the home and by the provider are protected from harm.

   e. Based on the findings of this immediate review, the Provider may be placed on Enhanced Monitoring or have other sanctions imposed, in accordance with the DDA Imposition of Provider Sanctions policy and related procedures.

C. Investigation Timelines

1. Once the death has been assigned, the MRC Coordinator is responsible for securing a complete record for the Investigation.

2. A death investigation shall be completed in 45 business days from the time the investigator receives the complete record. A draft report is expected within 40 business days after receiving initial written notice from DDS. For each day the complete record is

delayed, the investigator will have equivalent number of additional days to complete the report.

a. A complete record includes: medical records (including nursing notes, physician notes, assessments, screenings, and any other document which references health information), residential records, communication logs, hospital records, the OCME report (external physical examination or autopsy), ISP, death certificate (if available), EMS reports (if available), the provider's internal investigation, *Evans* Court Monitor reports, if any, IMEU reports, Quality Trust monitoring reports, if any, ULS reports, if any, and access to records in MCIS for a period of six to 12 months depending upon the type of death investigation ordered.

b. The MRC Coordinator will initiate a subpoena requesting the records from hospitals within 72 hours of notification.

D. Sanctions

DDS may sanction providers who do not comply with the mortality reporting and investigation processes, including the requirements of this procedure, in accordance with the DDA Imposition of Provider Sanctions policy and related procedures.

Attachments:

1. Mortality Notification Form
2. Immediate Safety Assessment and Monitoring Form