# 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)

# Six Basic Components of Mortality Reviews (GAO Report)

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.

# Screening Process (1)

- 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' – expected, unexpected but meets criteria of expected, unexpected

# Screening Process: Expedited Review Criteria

- Allows consistent determination of when an expedited review is indicated
  - Transitioned from a state operated facility within one year of the death
  - Trauma (e.g., accidental, abuse/neglect, drowning, homicide, suicide, unexplained injury)
  - Aspiration/choking when following criteria are met: (a) Without a prior diagnosis of severe chronic or terminal condition; (b) Diagnosed within 2 days of admission to a hospital or nursing home
  - Pneumonia when following criteria are met: (a) Without a prior diagnosis of severe chronic or terminal condition; (b) Diagnosed within 2 days of admission to a hospital or nursing home
  - Sepsis when following criteria are met: (a) Without a prior diagnosis of severe chronic or terminal condition; (b) Diagnosed within 2 days of admission to a hospital or nursing home
  - Sudden death (at the request of specific state agency staff)

# Screening Process: Additional Categorizations of Death

- Aspiration/choking with a prior diagnosis of severe chronic or terminal condition
- Pneumonia with a prior diagnosis of severe chronic or terminal condition
- Sepsis with a prior diagnosis of severe chronic or terminal condition
- Sudden death (with or without) a prior diagnosis of severe chronic or terminal condition
- Prolonged seizure or complications of seizure (with or without) a prior diagnosis of severe chronic or terminal condition
- Bowel obstruction (with or without) a prior diagnosis of severe chronic or terminal condition
- Official hospice case
- Known stage 3 or 4 heart failure (known severe chronic condition)
- Known symptomatic coronary artery disease (known severe chronic condition)
- Known severe renal failure (known severe chronic condition)
- Known severe liver failure (known severe chronic condition)
- Cancer with recurrence
- Severe stage of dementia
- Severe COPD or restrictive airways disease. Oxygen dependent 24 hours per day
- Neurological degeneration leading to chronic aspiration of airway secretions
- Pica
- Elopement
- Deaths reported to coroner/medical examiner
- Lack of appropriate non-emergency medical treatment that directly contributed to death
- Lack of appropriate response or delayed response by provider staff, emergency personnel, or a personal emergency response system

# Review of Unexpected Deaths, at a minimum (2)

## Reportable Deaths

- Death of any individual with IDD 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/IDD), 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 (3)

## Mortality Review Triage Team (MRTT):

- Mortality Review Physician
  - A board certified physician with experience working with the IDD population
- Mortality Investigator
- Mortality Review Intake Coordinator
- Incident and Mortality Review Director

## Mortality Review Committee:

- 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

# Document Mortality Review Process, Findings, or Recommendations (4)

- 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 30 day packet with MRTT
- Review follow up requested information with MRTT
- MRC
- Meeting minutes and MRC recommendations are forwarded to the State for review and approval

# Request for Documents (not limited to)

- Completion of 'Notification of Individual's Death' form
- Copy of death certificate
- Copy of autopsy report/coroner's report (if applicable)
- Individual Support Plan (ISP)
- Behavior Support Plan (BSP)
- Behavior documentation/notes
- Risk plans/health care plans, if applicable
- Monitoring sheets/treatment flow sheets (bowel tracking, fluid input/output record, seizure log, vital sign record, as required for the individual
- Medication administration records (MARs)/treatment records for 2 months
- Treatment record (most recent)
- Physician order sheet (most recent)
- Most recent physical exam completed by physician
- Physician consults/referrals in chronological order for 12 months preceding death
- PCP progress notes for 12 months preceding death
- Diagnostic tests and lab tests completed in chronological order for 12 months preceding death
- Discharge summaries for all hospitalizations for 12 months preceding death (including if individual died in the hospital)
- Most recent dietary guidelines/nutritional assessments

# Request for Documents (not limited to)

- Nurses notes (30 days)
- Progress notes/staff notes (30 days)
- Daily log sheets/daily support records (30 days)
- Staff schedules (30 days prior to death)
- Staff training records on individual-specific risk plans for staff who worked with him/her during the 30 days prior to death
- Current CPR cards for staff who worked with the individual during the 30 days prior to death
- Assigned staff ratios
- Copy of completed internal review of the death and supporting documentation including:
  - **Information, review, summary and findings**
  - **Description of all corrective actions developed as a result of the internal review (including timeframes for completion of each corrective action)**
  - **Documentation of implementation of any corrective actions developed as a result of the internal review**

# Review of submitted documents

- MRTT may request more documents for review to ensure health and safety
- MRTT meets again to review second round of documents and determines if health and safety have been assured
- If so, then case is considered a summary case
- If not, then case is made a focus for MRC review

# Use Mortality Information to Address Quality of Care GAO(5)

- From Feb 2012-June 2013, MRC referred 26 cases to the State for further investigation (on-site visit, review of submitted documentation, interviews with staff/individuals)
  - These 26 investigations identified 77 specific concerns
  - 63.4% of these concerns were substantiated
  - Most common findings from these investigations: medical needs not met, medication errors, administration concerns, risk plans not followed or insufficient documentation, BSP not updated, BSP not followed, inadequate staff training for BSPs
  - Of the 26 cases, 18 provider agencies had at least one substantiated issue requiring corrective action from the provider.

# Aggregate Mortality Data Over Time to Identify Trends -GAO(6)

- Have data for 1,947 deaths during the time period of 10/1/08-8/31/13.
- Reviewed specific common causes of death:
  - Sepsis
  - Cardiovascular disease
  - Respiratory disease (noninfectious)
  - Cancer
- These 4 causes contributed to 52% of all deaths.

# Analysis of Mortality Data (continued)

- Deaths peaked in the 50s and 60s for those with borderline, mild, moderate, and severe IDD.
- For profound IDD:
  - For those with profound IDD, there was a double peak of mortality, an early peak under the age of 30 and a second peak in the 50s.
  - Approximately half of all deaths under the age of 30 occurred in those with profound IDD.

# Analysis of Mortality Data (continued)

- For profound IDD population:
  - Second peak is most challenging medically, with two sets of comorbid conditions.
  - Conditions common to the IDD population.
  - Onset of geriatric syndromes.
  - Respiratory causes (noninfectious) responsible for 24% of deaths in those under age 30.
  - 1/3 of all deaths due to respiratory (noninfectious) causes occurred in the profound IDD population.

# Analysis of Mortality Data (continued)

- Sepsis contributed to 6-11% of all deaths in all decades.
- In the IDD waiver setting,  sepsis caused 12% of all deaths.
- Cardiovascular disease caused 17-22% of all deaths in the borderline, mild, moderate, and severe IDD population.
- Cardiovascular deaths peaked in the 50s, 60s, and 70s.

# Analysis of Mortality Data (continued)

- Respiratory deaths (noninfectious) peaked in the 60s.
- Cancer deaths peaked in the 50s.
- Contrasting two subpopulations:
  - 39% of cardiovascular deaths and 51% of cancer deaths occurred in the mild IDD population.
  - 22% of cardiovascular deaths and 9% of cancer deaths occurred in the profound IDD population.

# Analysis of Mortality Data (continued)

| TABLE 1. SELECTED CAUSES OF DEATH PER DECADE OF LIFE - deaths reviewed by MRC 10/1/08 to 8/31/13 | | | | | |
|---|---|---|---|---|---|
| Decade | Total Number of Deaths | Cardio-vascular | Respiratory | Cancer | Sepsis |
| <30 | 157 | 19 | 38 | 6 | 15 |
| 30s | 142 | 21 | 20 | 11 | 13 |
| 40s | 202 | 34 | 31 | 15 | 15 |
| 50s | 432 | 78 | 49 | 58 | 48 |
| 60s | 477 | 90 | 73 | 50 | 43 |
| 70s | 318 | 74 | 33 | 27 | 35 |
| 80s | 186 | 45 | 19 | 22 | 12 |
| 90+ | 33 | 5 | 2 | 2 | 2 |
| Total | 1947 | 366 | 265 | 191 | 183 |

# Analysis of Mortality Data (continued)

- Dysphagia and GERD were common at all ages at time of death.
- For those with a lifespan under 30 years, 48% had a g-tube, and 62% had seizures.
- For deaths in the 5th decade, associated conditions included Down's syndrome (28%), hypothyroidism (32%), and seizures (52%).
- For deaths in the 6th decade, comorbid conditions included dementia (34%), hypothyroidism (29%), and seizures (43%).

# Analysis of Mortality Data (continued)

| TABLE 2. VARIOUS HEALTH CATEGORIES PER DECADE OF LIFE - deaths reviewed by MRC 10/1/08 to 8/31/13 | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Total | Various Health Categories | | | | | | | | |
| Decade | Number of Deaths | Dementia | G tube | Down's | Dysphagia | CVA | GERD | Hypothyroidism | Sleep Apnea | Seizures |
| <30 | 157 | 1 | 75 | 5 | 37 | 9 | 45 | 15 | 19 | 97 |
| 30s | 142 | 1 | 43 | 13 | 40 | 7 | 53 | 32 | 17 | 81 |
| 40s | 202 | 24 | 61 | 32 | 69 | 11 | 79 | 60 | 26 | 96 |
| 50s | 432 | 114 | 81 | 121 | 162 | 24 | 174 | 140 | 43 | 225 |
| 60s | 477 | 164 | 95 | 86 | 188 | 51 | 221 | 140 | 38 | 205 |
| 70s | 318 | 113 | 49 | 9 | 121 | 42 | 148 | 89 | 20 | 104 |
| 80s | 186 | 96 | 31 | 0 | 82 | 27 | 86 | 39 | 3 | 49 |
| 90+ | 33 | 23 | 2 | 0 | 11 | 3 | 13 | 5 | 0 | 3 |
| Total | 1947 | 536 | 437 | 266 | 710 | 174 | 819 | 520 | 166 | 860 |

# Mortality/Comorbid Data (continued)

- Valid sources for identifying comorbid conditions include:
  - Developmental Disability Profile
  - Physician initial admission information
  - Diagnoses on physician order sheet
  - Indication listed on MAR
  - Consultation reports
- A comorbid condition is often not listed as primary or contributing diagnosis on death certificate
- Require careful review of submitted documents

# Mortality/Comorbid Data (continued)

- Several common comorbid conditions are captured if justified by documentation
  - Comorbid conditions may have had no impact on cause of death
  - Some comorbid conditions have been tracked since inception of database. Others have been added when frequency justified tracking.

# Mortality/Comorbid Data (continued)

- Comorbid conditions currently being captured for further analysis and subsequent action include, but are not limited to:
  - G-tube placement
  - Down's syndrome
  - Dysphagia
  - CVA
  - GERD
  - Hypothyroidism
  - Sleep apnea
  - Seizures
  - Diabetes mellitus
  - Diabetes insipidus
  - Renal failure

# Four Additional Components of Mortality Reviews (GAO Report)

1. Use a state-wide 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 state-wide action based on mortality information to systemically improve care
4. Publicly report mortality information

# Use a state-wide interdisciplinary mortality review committee (e.g., overseen by developmental disabilities agency) (1)

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 (e.g., protection and advocacy agency) (2)

External membership of MRC includes representatives from:

- Family member of person(s) with IDD
- Community advocates for IDD population
- Adult Protective Services (APS)
- Coroner

# Take statewide action based on mortality information to systemically improve care (3)

- 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
- Used when requesting follow-up reports for incidents
- Used as an aid when developing a comprehensive quality risk plan

# Major Section Headings for Risk Checklists

- General Questions
- After the Incident
- Staffing Issues/Staff Training Issues
- Environmental Issues to Consider
- Monitoring by Staff
- Monitoring by Management
- Pertinent Documentation

## Issues to be Reviewed and Addressed when a Person Has Had a Choking Incident

**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**

| Requested | Date Received | | GENERAL QUESTIONS |
|---|---|---|---|
| ☐ | | 1 | What was the item the person choked on? If not known, then what was the last item he/she ate? |
| ☐ | | 2 | Where was the person at the time of the incident (e.g., dining table, couch, bed, etc.) |
| ☐ | | 3 | Was there a dining/choking risk plan in place prior to the choking incident? If so, was the plan being followed? |
| ☐ | | 4 | Have there been any previous choking episodes? If so, when? |
| ☐ | | 5 | Does the person have difficulty chewing or swallowing? |
| ☐ | | 6 | Does the person have a specialized diet texture/ fluid consistency ordered (pureed, chopped, thickened liquids, etc.)? |
| ☐ | | 7 | Does the person have a positioning plan during mealtime? If so, was the plan followed at the time of the incident? |
| ☐ | | 8 | What is the person's level of supervision during meals (and snacks)? |
| ☐ | | 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? |
| ☐ | | 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? |
| ☐ | | 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? |
| | | | **UNSAFE EATING ISSUES** |
| ☐ | | 12 | Does the person engage in unsafe eating habits (rapid rate of eating, stuffing mouth, taking large bites, pica, etc.)? |
| ☐ | | 13 | Was there food within reach if this is a risk for the person? |
| ☐ | | 14 | Does the person have formal dining objectives in place to address the unsafe eating habit(s)? |
| ☐ | | 15 | Is the person on medications known to increase appetite? |
| ☐ | | 16 | If the person has food-stealing behaviors, does he/she have increased supervision and/or decreased access to food? |
| | | | **STAFFING ISSUES/STAFF TRAINING ISSUES** |
| | | | Note: Training should be competency-based (hands-on implementation of procedures to ensure staff understand and can perform) |
| ☐ | | 17 | Were staff following the required level of supervision/monitoring (including required proximity to the person) during the incident ? |
| ☐ | | 18 | How long had the staff on duty during the choking incident been working with the person? (e.g., years, months, weeks, days, etc) |
| ☐ | | 19 | Was the staff working overtime when the incident occurred? |
| ☐ | | 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. |
| ☐ | | 21 | Are all staff, in all settings, trained to competency on 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.? |
| | | | **ENVIRONMENTAL ISSUES TO CONSIDER** |
| ☐ | | 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.) |
| ☐ | | 23 | How are food items secured in cases of risk (without restricting anyone's rights and appropriate access to food items)? |
| ☐ | | 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.)? |
| | | | **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 gray-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) |

| | |
|---|---|
| **Name** | |
| **Date of Choking Incident** | |
| **Time of Choking Incident** | |
| **IR #** | |

## FOODS IDENTIFIED WITH CHOKING EPISODE

| Type | 2010 (Sept=Dec) | 2011 | 2012 | Total |
|---|---|---|---|---|
| Meat except hot dog category | 23 | 73 | 69 | 165 |
| Hot dog category | 0 | 13 | 14 | 27 |
| Complex/ starch | 11 | 39 | 57 | 107 |
| Sandwich category | 6 | 24 | 21 | 51 |
| Vegetable | 4 | 16 | 21 | 41 |
| Potato category | 2 | 12 | 14 | 28 |
| Fruit | 3 | 10 | 12 | 25 |
| Medication | 0 | 8 | 10 | 18 |
| Pizza | 2 | 5 | 8 | 15 |
| Melon | 2 | 3 | 6 | 11 |
| Rice | 0 | 4 | 4 | 8 |
| Salad | 1 | 2 | 4 | 7 |
| Candy | 0 | 3 | 4 | 7 |
| Peanut Butter | 0 | 5 | 1 | 6 |
| Pica | 1 | 3 | 1 | 5 |

| | | | | |
|---|---|---|---|---|
| Total events reported | 53 | 204 | 249 | 506 |

## INTERVENTIONS IDENTIFIED WITH CHOKING EPISODE

| Intervention | 2010 | 2011 | 2012 | total |
|---|---|---|---|---|
| Abdominal thrusts | 43 | 142 | 150 | 335 |
| Back blows | 8 | 52 | 39 | 99 |
| Neither when CPR not indicated | 4 | 22 | 69 | 95 |
| Emergency Room Visit | 26 | 88 | 125 | 239 |

## Incident Resulting in a Fracture Checklist

**Instructions:**

**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.

| Initial | # | GENERAL QUESTIONS |
|---|---|---|
| | | **WAS THERE A FALL?** |
| ☐ | 1 | Was there a prior fall (with or without injury) in the past six months? |
| ☐ | 2 | Does the person have a known "fear of falling?" |
| ☐ | 3 | What was the activity at the time of the fall? |
| ☐ | 4 | What was the location of the fall (e.g., kitchen, bathroom, sidewalk, etc.)? |
| ☐ | 5 | What type of surface did the person land on? |
| ☐ | 6 | If from a height, how far did the person fall? |
| ☐ | 7 | If the fall occurred outside, what was the temperature and weather conditions at the time? |
| ☐ | 8 | Was there a use of restraint at the time of the fall? If so, what kind? |
| ☐ | 9 | Was there a challenging behavior exhibited at the time of the fall? |
| ☐ | 10 | If #9 is yes, what was the staff's response to reduce the behavior prior to the fall? |
| ☐ | 11 | If #9 is yes, was there a behavior support plan? |
| ☐ | 12 | Were there any signs of illness/unsteadiness prior to the fall? |
| ☐ | 13 | Was the fall associated with a new onset of a medical problem? |
| ☐ | 14 | Does the person have a known medical problem which contributes to falls? |
| ☐ | 15 | Does the person use assistive devices for ambulation? |
| ☐ | 16 | Were there any recent medication changes (e.g., new medications, change in dosage of old medications, new over-the-counter medications, etc.)? |
| ☐ | 17 | Did the environment contribute to the fall (e.g., poor lighting, loose rugs, cords on the floor, worn footwear, shoelaces, glare, slippery floors, etc.)? |
| ☐ | 18 | How has the team addressed preventing another fall? |
| ☐ | 19 | Was an updated fall risk assessment completed after the fall? |
| ☐ | 20 | Is there use of preventive health programs (e.g., exercise program, strengthening, PT, OT, home evaluation by OT, personal emergency response system (PERS), etc.)? |
| ☐ | 21 | Was there a recommendation for an assistive device? |
| ☐ | 22 | Have any other changes been implemented (e.g., footwear, environmental improvements, etc.)? |
| ☐ | 22.1 | Was a fall prevention plan in place prior to the incident? If so, was the plan being followed at the time of the incident? |
| | 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) |

Name

Date

3/15/2011

## FRACTURE INCIDENT REPORTS

| Fracture location | 2011 (Feb-Dec) | 2012 | Total | |
|---|---|---|---|---|
| Toe | 46 | 53 | 99 | |
| Finger/thumb | 51 | 42 | 93 | |
| Foot | 48 | 40 | 88 | |
| Ankle | 39 | 39 | 78 | |
| Femur/hip | 37 | 37 | 74 | |
| Tibia/fibula/ knee/leg NOS | 36 | 36 | 72 | |
| Elbow/forearm/wrist | 27 | 41 | 68 | |
| Nose | 28 | 32 | 60 | |
| Shoulder/humerus | 30 | 21 | 51 | |
| Hand | 23 | 24 | 47 | |
| Sternum/rib | 20 | 18 | 38 | |
| Clavicle | 15 | 22 | 37 | |
| Spine | 8 | 12 | 20 | |
| Face | 4 | 16 | 20 | |
| Arm (NOS) | 9 | 10 | 19 | |
| Pelvis | 9 | 4 | 13 | |
| Neck | 2 | 4 | 6 | |
| Teeth | 2 | 0 | 2 | |
| Skull | 0 | 1 | 1 | |
| Not specified | 1 | 0 | 1 | |

| | | | | |
|---|---|---|---|---|
| Total fractures | 435 | 452 | 887 | |
| Total incidents | 421 | 437 | 858 | |

| | | | | |
|---|---|---|---|---|
| Upper extremity fx | 155 | 160 | 315 | 315/887=36% |
| Lower extremity fx | 206 | 205 | 411 | 411/887=46% |
| | | | | |
| Fx due to seizure | 28 | 28 | 56 | |

# DECUBITUS ULCER CHECKLIST

**Instructions:**

**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.**

| Issue | # | GENERAL QUESTIONS |
|---|---|---|
| ☐ | 1 | What is the stage of the ulcer (stage I, II, III, IV)? |
| ☐ | 2 | Is there a diagnosis that can contribute to ulcer development (e.g., spina bifida, terminal cancer, etc.)? |
| ☐ | 3 | Was there a decline in functional status prior to ulcer development? If so, include the reason for decline (e.g., stroke, worsening dementia, heart failure, etc.). |
| ☐ | 4 | Was a Braden Scale of Pressure Ulcer Risk Assessment completed? If so, include the date of assessment. |
| ☐ | 5 | When was the ulcer first discovered? When was the most recent head-to-toe assessment completed prior to discovery of a decubitus ulcer? What was the date of the last document indicating skin had no signs of injury (no decubiti noted)? |
| ☐ | 6 | Is there a written positioning schedule? |
| ☐ | 7 | If appropriate to the location of the ulcer, what type of mattress has been used (name, brand, description)? How long has it been in use for this person? |
| ☐ | 8 | What is the level of mobility (e.g., ambulatory, chair bound, bed bound, quadriplegic)? |
| ☐ | 9 | Are any devices (e.g., wedges, heal protectors, etc.) used to relieve pressure at that body site and/or other sites? |
| ☐ | 10 | Are there any positioning aids (e.g., trapeze, bed rails, etc.) being used? |
| ☐ | 11 | If there is a wheelchair, is it being used? Are footrests being used? |
| ☐ | 12 | Is there a bowel and bladder toileting program? |
| ☐ | 13 | What is the date of the last physical therapy assessment? |
| ☐ | 14 | What is the date of the last occupational therapy assessment? |
| ☐ | 15 | What is the date the decubitus ulcer is considered healed? |
| ☐ | 16 | Is there a history of prior decubiti? If so, indicate date of onset, stage and location. |
| ☐ | 17 | Describe the type of dressing being utilized. |
| ☐ | 18 | Have there been any complications (e.g., abscess, cellulitis, sepsis, osteomyelitis)? |
| ☐ | 19 | Was a wound clinic/wound specialist consulted? |
| | | **RELATED TO HOSPITAL STAY** |
| | 20 | If the person returned from the hospital with a decubitus ulcer: |
| ☐ | a. | Was an ulcer present prior to transfer to the hospital? |
| ☐ | b. | Is a copy of the transfer packet of information sent to the hospital available? |
| ☐ | c. | Was a skin assessment completed prior to transfer to the hospital? |
| ☐ | d. | Was a skin assessment completed upon return from the hospital? |
| ☐ | e. | What was the stage upon the return from the hospital (include location(s), dimension(s), etc.)? |
| | | **NUTRITIONAL ISSUES** |
| ☐ | 21 | What is the date of the last nutritional assessment? |
| ☐ | 22 | Are dietary supplements (e.g., formula, zinc, vitamins) provided? |
| ☐ | 23 | Is intake recorded? If so, who reviews this intake log? What is the frequency of the review? |
| ☐ | 24 | What is the most recent albumin level (along with date)? (or other lab values followed by agency) |
| | | **MONITORING AND DOCUMENTATION** |
| ☐ | 25 | What are the monthly weights for the past six months? |
| ☐ | 26 | Include the temperature record for the past 30 days. |
| ☐ | 27 | Is pain monitored? How is it recorded? What treatment is provided? |
| ☐ | 28 | Are serial photographs used to document change in the decubitus ulcer? |
| ☐ | 29 | Is there a measuring tool in the photographs? |
| ☐ | 30 | Is there a decubitus tracking/monitoring log? How is the decubitus ulcer monitored? |
| ☐ | 31 | Include the dates of all team meetings within the past six months about decubitus care and progress. |
| | | **STAFF TRAINING ISSUES** |
| | | Note: Training should be competency-based (hands-on implementation of procedures to ensure staff understand and can perform) |
| ☐ | 32 | Have direct support staff been formally trained on decubitus care/prevention? |
| | | **MONITORING BY MANAGEMENT** |
| ☐ | 33 | Have other individuals in this home experienced decubitus within the past 12 months? |
| | | **PERTINENT DOCUMENTATION** |
| ☐ | 34 | **Copy of person's risk plan relative to decubitus ulcers** |
| ☐ | 35 | **Copy of person's positioning plan/schedule** |
| ☐ | 36 | **Copy of person's Braden Scale of Pressure Ulcer Risk Assessment** |
| ☐ | 37 | **Staff training records regarding decubitus care/prevention (ALL settings - home and day programs)** |
| | | Note: Training should be competency-based (hands-on implementation of procedures to ensure staff understand and can perform) |

**Name:**

**Date:**

3/15/2011

## DECUBITUS ULCER LOCATION

| Location | 2011 (April-Dec) | 2012 | total | % of all ulcers |
|---|---|---|---|---|
| | | | | |
| **Buttocks** | 21 | 48 | 69 | 39% |
| **Coccyx** | 4 | 19 | 23 | 13% |
| **Heel** | 6 | 10 | 16 | 9% |
| **Hip** | 4 | 11 | 15 | 8% |
| **Foot** | 7 | 6 | 13 | 7% |
| **Leg/knee** | 2 | 7 | 9 | 5% |
| **Back, other** | 2 | 3 | 5 | 3% |
| **Toe** | 2 | 4 | 6 | 3% |
| **Pelvis, other** | 2 | 2 | 4 | 2% |
| **Perineum** | 3 | 0 | 3 | 2% |
| **Ankle** | 1 | 3 | 4 | 2% |
| **Abdomen** | 2 | 0 | 2 | 1% |
| **Elbow** | 0 | 1 | 1 | <1% |
| **Not recorded** | 4 | 4 | 8 | 4% |
| **Total ulcers** | 60 | 118 | 178 | |
| **Total individuals** | 59 | 101 | 160 | |
| **More than 1 ulcer on individual** | 1 | 17 | 18 | |

## DISLODGED/DISPLACED TUBE CHECKLIST

**Instructions:**

**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.**

| Issue | # | GENERAL QUESTIONS |
|---|---|---|
| ☐ | 1 | Where did it occur (e.g., during transport, in the bedroom, etc.)? |
| ☒ | 2 | Was feeding in progress? |
| ☐ | 3 | What was the activity (e.g., preparing to bathe, recreation, getting into a vehicle, found dislodged while asleep, etc.) at the time the tube was dislodged? |
| ☐ | 4 | Was the tube inadvertently caught on clothing, furniture or other item? |
| ☐ | 5 | Was the tube being purposely adjusted/moved in or out of the abdomen, when it was dislodged? |
| ☐ | 6 | Did the tube have markings or numbers indicating the distance in or out of the abdomen (usually at the level of the collar or external bumper)? If so, how often is it read and recorded? |
| ☐ | 7 | Is the length of the tube outside of the body recorded on a log or in a progress note? If so, how often? |
| ☐ | 8 | If there is a change in the level recorded, is this change documented? Who is informed of the change? |
| ☐ | 9 | Was this tube ever in too far? If so, when? |
| ☐ | 10 | Did the person pull the tube out? If so, was it intentional or unintentional? Was it observed or unobserved? |
| ☐ | 11 | Was the displacing preceded by severe coughing or vomiting? |
| ☐ | 12 | How was the tube anchored to the body? |
| ☐ | 13 | Was an external bumper/disc or collar in place? |
| ☐ | 14 | If it was not, when was it last observed to be in place? |
| ☐ | 15 | If it was in place, how often is it checked? |
| ☐ | 16 | When was the last date/time of documentation that it was checked? |
| ☐ | 17 | Was there an internal balloon? If so, was it still inflated or ruptured when displaced? |
| ☐ | 18 | How long had the tube been out? If not known, when was it last noted to be in place? |
| ☐ | 19 | When was the last time (date, shift, hour) the tube was dislodged? |
| ☐ | 20 | When was the last time the tube was routinely replaced/changed? |
| ☐ | 21 | What was the date of the original placement of this tube? |
| ☐ | 22 | Has the person ever had a gastric button to replace the external tubing? |
| | | **AFTER THE INCIDENT** |
| ☐ | 23 | What changes have been made to prevent further incidents of a dislodged/displaced tube? |
| | | **STAFFING ISSUES/STAFF TRAINING ISSUES** |
| | | Note: Training should be competency-based (hands-on implementation of procedures to ensure staff understand and can perform) |
| ☐ | 24 | Have direct support staff been formally trained on the care of the feeding tube? |
| ☐ | 25 | What was the staffing ratio at the time the tube was dislodged/displaced or presumed to have been dislodged/displaced? |
| ☐ | 26 | What should the staffing ratio have been at that time? |
| | | **MONITORING BY MANAGEMENT** |
| ☐ | 27 | How often is the condition of the tube observed by a team member other than direct support staff? |
| | | **PERTINENT DOCUMENTATION** |
| ☐ | 28 | Training records regarding care of feeding tube for staff on duty 24 hours prior to the displaced tube being found |
| ☐ | 29 | Copy of documentation regarding the length of the tube outside of the body |
| | | Note: Training should be competency-based (hands-on implementation of procedures to ensure staff understand and can perform) |

| | |
|---|---|
| Name | |
| Date | |

# Publicly Report Mortality Information (4)

- Periodic/quarterly communications available on the website of the QI IDD 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 served

# Risk Management Process that has Grown out of the Presented Mortality Review Process

- 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

- Each death is reviewed within 24 hours of notification by risk physician and discussed during a Mortality Review Triage Team (MRTT) meeting
- The review includes:
  - The initial death of person incident report
  - Incident reports submitted for the individual for the 60 days prior to death or the 60 days prior to hospitalization/transfer to a nursing home
  - Identification of any housemates
  - Incident reports submitted for housemates for the prior 60 days

# Anyone Else at Risk Initiative (continued)

- 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 at Risk Initiative (continued)

- 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: Decision Tree

- MRTT requests additional information
- Initiate the complaint referral process for potential on-site survey/review
  - Bureau of Quality Improvement Services if the person was receiving waiver services
  - Department of Health if a person was in a supported group living (SGL) home

# Anyone Else: If MRTT Identifies Concerns

- The provider agency is requested to submit specific documents for housemates concerning:
  - Similar clinical areas (e.g., request for comprehensive list of diagnoses, list of medications, etc.)
  - Documentation of staff training records
- A follow-up review of additional information is presented to the MRTT. Either health and safety is assured, or there are ongoing concerns requiring further information or referral for an on-site survey/review (refer back to decision tree)

# Anyone Else at Risk Initiative (continued)

- 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 statewide Mortality Review Committee (MRC) review
- Have reduced the process by 1-3 months. No longer wait for a complete summary to be created of submitted information, followed by presentation to MRC.
- Have triaged cases. 16 of 38 (42%) MRTT requested and reviewed documents for housemates and did not require an on-site survey/review.

# Example of a referral for a home under jurisdiction of DoH:

*Per document review, individual did not need to have her diet modified; however, her housemates did. There is a highlighted section in the attached document that indicates the food wasn't prepared to the correct consistency which raises the question – are the housemates at risk - seven other people live in this home.*

# Example of a referral for a home under jurisdiction of BQIS

*Review agency's policy/procedure/protocol regarding staff training. Is the process a 'read and sign' process? What is the agency's policy on ensuring staff are trained to competency prior to working with consumers and when changes are made to plans? Verify via staff interview and home visits.*

# Example of a referral for a home under jurisdiction of BQIS

*What is the agency's QA system to ensure consistency of documents, plans are implemented as written, and staff know where to find documents when they need to reference something? (Two staff indicated they did not thicken liquids because they didn't know it was needed.) Verify via staff interview and home visits.*

# Example of a referral for a home under jurisdiction of BQIS

*Review of agency's policy/procedure/protocol regarding actions in emergency situations (call supervisor, call 911, etc.). Is staff supposed to call the supervisor prior to calling 911? (Per document review, that is what happened in this case.) Need to ensure all staff are retrained on what to do in the event of an emergency. Verify via staff interview and home visits."*

# Anyone Else: Upon Review, MRTT Requested Additional Information

- *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: Upon Review, MRTT Requested Additional Information

- *Clarification on the clinical recommendation regarding the length of time individual was to remain upright following eating (inconsistency between several documents that staff would refer to).*
- *Clarification on the clinical recommendation of the correct height for individual's head of bed (HOB).*
- *Clarification on whether staff are trained to competency regarding: correctly elevating the HOB for other people with this diagnosis.*
- *Correctly knowing and implementing the length of time specific people should remain upright following eating for others with this diagnosis.*
- *Having accurate knowledge regarding consistency of liquids for specific people and demonstrating this knowledge (actually thickening a liquid to various consistencies) for a surveyor.*

# 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.*
- *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).*

# Thank you!

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