SOUTHERN HIGHLANDS COMMUNITY MENTAL HEALTH CENTER

POLICY AND PROCEDURE MANUAL

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Policy 177 – Mortality Review

I. POLICY

It is the policy of Southern Highlands Community Mental Health Center in the event of a consumer's death to conduct an in-depth review of the care and treatment of that consumer in which the Center was involved and to submit the findings of that review to the Chief Executive Officer and the Director of the Bureau of Behavioral Health and Health Facilities.

II. PURPOSE

To review circumstances and causes relating to the death of consumers in state-operated facilities and specified programs of Licensed Behavioral Health Providers or other Department contract agencies. It is important to review the causes and circumstances surrounding the deaths to learn from them and to assure that appropriate care has been given to these consumers.

III. DISCUSSION

Whenever a consumer's death occurs during a Center sponsored activity, it is important that the event be regarded as a possible serious violation of the consumer's need for safety. While it is recognized that some accidents and deaths are not preventable, it is incumbent upon the Center to review all such occurrences to ensure that they are kept at a minimum.

IV. PROCEDURES

In the event of the death of a consumer who has been in **active** treatment within the preceding 90 days prior to death, and/or

- the death is a suicide or suspected suicide within our agency; or
- suspected or confirmed overdose from medication prescribed by a provider of SHCMHC, or
- the consumer has received emergency/crisis services, or been in the Crisis Stabilization Unit or a Residential SUD Unit within 24 hours of the death; or
- the consumer is in a 16-24-hour residential or day treatment program operated by the agency.

A. Once the agency and/or its staff are notified of the death of a consumer in the aforementioned instances, the Chief Executive Officer and / or the Chief Residential & Compliance Officer, or his/her designee, is to be notified immediately, or as soon thereafter as practical, by telephone and then in writing within 24 hours. An Adverse Incident Report will be used for reporting purposes.

B. If the death occurs after the transfer from the behavioral health center to a hospital or other medical treatment facility it will be SHCMHC responsibility to report and investigate the incident to the full extent possible given the information available to SHCMHC at the time of transfer.

C. Consumers served by multiple agencies under the Title XIX Waiver program must have an investigation conducted and submit the results to OHFLAC. I/DD Waiver Case Managers will follow Title XIX Waiver guidelines for any Title XIX Waiver consumer that has deceased.

D. If the death of consumers that only received outpatient services was not related to any services provided by SHCMHC (e.g., natural causes, accidental death, vehicle wreck, etc.) does not need reported or investigated

E. Behavioral Health Center Initial Mortality Report (see attachment) will be completed and submitted to the Office of Health Facility Licensure & Certification (OHFLAC) within twenty-four hours (24) of knowledge of the mortality. If more information is requested by OHFLAC, that information will be sent as requested.

F. A formal review of the circumstances and causes surrounding the death shall be conducted by the Chief Residential & Compliance Officer or designee which shall address:

- Was the treatment provided in accordance with accepted professional practice and applicable Center policies/procedures, for example, were medications ordered and monitored in accordance with agency policies/procedures?

- Was the death related to the consumer's behavioral health problem, i.e., a suspected or known suicide – an accident that could have been prevented?

- Could medication reactions have played a part or been responsible for the death?

- Was there any indication that the consumer needed medical services or other assistance they did not receive, i.e., was the consumer known to have complained of physical symptoms?

- What could the Center have done that might have improved care for this consumer?

- What, if any, procedures/practices need to be reviewed and revised?

G. A copy of the results of these proceedings shall be filed with the Bureau of Behavioral Health and Health Facilities if requested.

H. Upon notification of a death that is criminal in nature or due to an unusual event, the Medical Records supervisor will ensure access to the chart will be limited to the Chief Executive Officer and his/her designee.

I. All mortality reports will be reviewed by the Incident Report Committee at monthly meetings.

J. All internal investigations cannot be release outside of DHHR without a court order.