NEW JERSEY HUMAN SERVICES | Division of Developmental Disabilities

Mortality Review Process

DDD Mortality Review Unit

Overview

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Trauma Informed Care

- The Division understands the passing of individuals is very sensitive in nature and makes all efforts to be respectful to families, support coordinators, and providers when communicating about such events.
- The Division encourages all stakeholders working with individuals and families to take a trauma informed approach.
- Provider agencies are encouraged to utilize grief resources as needed and consider implementing grief supports for staff and other individuals served, as appropriate.

Mortality Review Unit

- The Mortality Review Unit (MRU) is overseen by the Office of Risk Management.
- The MRU is comprised of four state employees:
  - Chief of Data and Quality
  - Quality Assurance Coordinator (QAC)
  - Quality Assurance Specialist (QAS)
  - Senior Community Program Specialist (SrCPS)

Incident Reporting

- Deaths are reportable under Administrative Order 2:05 via code DT101.
- Per Division Circular 14, all employees of the Division and anyone that provides services to Division eligible individuals are mandatory reporters.
- It is the responsibility of provider staff and support coordination staff to report incidents if they become aware of a reportable event or allegation.
- Incident reports regarding deaths should be submitted the same business day.

Incident Reporting

- Reporters should include as much detail as possible, including but not limited to:
  - Time and place of death;
  - Names of all staff present at the time of the passing;
  - What occurred leading up to the passing of the individual?;
  - What was the individual's level of supervision at the time of their passing?;
  - What was the individual's demeanor?;
  - Was supervision maintained? (i.e. were overnight checks provided);
  - What first aid or treatment was provided (include whether 911 was called or CPR was administered)?;
  - What other immediate actions were taken by staff?

Incident Reporting

- Upon review and analysis of all death incidents, MRU staff document demographic and circumstantial information into the New Jersey Incident Reporting and Management System (NJIRMS).
- Information includes, but is not limited to: date of death; primary and secondary causes of death; manner of death; fatal conditions that were present; etc.
- A summary of the circumstances leading up to the individual's passing is also documented.
- MRU staff upload a copy of the individual's death certificate and Medicaid claim history to NJIRMS

Incident Reporting

- An incident may be closed by MRU staff when the following circumstances are satisfied:
  - The death certificate is received (auto-populates in iRecord);
  - There is no outstanding information requested from any entity such as a provider or medical examiner;
  - Remedial actions are documented by a provider to address any preventable issues that occurred (Mortality Follow Up Form);
  - All instances of neglect or preventability are addressed and referred to the appropriate entities, as needed.

Mortality Review Process

- The MRU reviews all incident reports coded for death as they are received by the Division.
- This includes individuals enrolled on the Community Care Program and Supports Program, as well as individuals who may not currently be enrolled in waiver program.
- Reoccurring Mortality Review Meetings occur for unexpected deaths in licensed residential settings.
- Deaths in other settings or under other circumstances may be reviewed at biweekly meetings if needed.

Mortality Review Process

- MRU meets on a regular basis to review unexpected deaths that occur in licensed residential settings (group home, supervised apartment, etc.), or where the individual's last know living arrangement was a licensed setting.
- On a case-by-case basis, MRU reviews unexpected deaths occurring in unlicensed settings, such as family homes and nursing facilities, to assess for neglect and preventability.
- As applicable, MRU will refer death incidents to the Office of Program Integrity and Accountability (OPIA) for review and potential investigation.

Mortality Review Process

Always Reviewed:	Reviewed if available/pertinent:
The individual's death certificate	Police Report
Medicaid Shared Data Warehouse	Computer Aided Dispatch (CAD) Report
Mortality Follow-up Form (MFF)	Emergency Services Patient Care Report
New Jersey Incident Reporting and Management System (NJIRMS) History	Hospital documents including discharge documents, ER Report, etc.
Individualized Service Plan	Autopsy Results
Support Coordination Monitoring Tools	Toxicology Results
iRecord Case Notes	Medical Examiner Report

Mortality Review Process

- Mortality Follow-up Form (MFF)
  - The Mortality Follow-up Form (MFF) was developed collaboratively by the Division and OPIA to streamline the collection of information about deaths of individuals who reside in licensed settings. The MFF may be requested for deaths that occur in other settings at the discretion of Division or Department staff.
    - The MFF should be submitted within 14 days of the individual's passing.
    - The MFF can be submitted after the initial incident report.

Mortality Review Process

- Mortality Follow-up Form (MFF)
  - The timeline section of the form should sufficiently reflect, in itemized detail, what occurred the hours leading up to an individuals' passing. It should not be the same as the description of the initial incident report.
  - MRU staff will review the MFF "Actions" section for information about how the provider will prevent future occurrence of similar incidents, if there were preventable factors involved. Providers should report actions similar to how they report them in a "plan of correction" after a DHS Investigation.
  - If the provider continually fails to respond with submission of the form or incomplete information, they will receive a communication noting they are in Failure to Comply status and the DHS Office of Licensing will be notified.

Mortality Review Process

Focus	Recognizing Risk	Planning	Action	Communication
Description	Staff did not recognize signs of illness or other risk factors that could have helped prevent a death.	Staff did not plan in accordance with an individual's ISP where risk was recognized. Planning could have helped to prevent a death.	Proper evaluation and planning happened, but there was no follow-up action in a timely manner that could have helped to prevent a death.	Staff did not communicate or notify others of identified risks or concerns that could have mitigated the risk and helped to prevent a death.
Example	Staff did not recognize they should complete bowel movement tracking for someone with chronic constipation who was under treatment from a gastroenterologist. The individual was not receiving related PRN medication and passed from a bowel blockage.	Staff did not plan appropriately or bring equipment to modify food to an individual's prescribed diet texture. The individual died as a result of a choking incident.	Staff did not act appropriately and follow the documented diabetes protocol for someone with Type 1 Diabetes. Staff did not call 911 when the individual's blood sugar was 500. The individual passed from diabetic ketoacidosis.	Staff needed to use the restroom, left an individual unsupervised and did not communicate to fellow staff that the supervision needed to be maintained. As a result the individual fell and suffered a fatal head injury.

Checks and Balances

- Medicaid Death Crosswalk
  - On a monthly basis, MRU receives a list of individuals receiving services who Medicaid has documented as deceased.
  - MRU reviews this list to ensure incident reports have been filed for all identified individuals.
  - If an incident report is needed, MRU staff request the IR submission from the provider, Support Coordinator (SC) or Case Manager (CM).
  - If the individual is “inactive”, such as someone living in a nursing facility, and there is no SC or CM, MRU staff will generate the incident report.

Checks and Balances

- Death Acknowledgements
  - On a weekly basis, MRU staff receive a list from Division IT of all deaths that have been confirmed in iRecord for the previous week.
  - MRU reviews this list to ensure incident reports have been filed for all identified individuals.
  - If an incident report is needed, MRU staff request the IR submission from the SC or CM.

Checks and Balances

- Department of Health Referrals
  - If a death:
    - Occurs in a setting overseen by the Department of Health (i.e. hospital or nursing facility)

    and

    - Neglect or preventable circumstances appear to be present

    then

    - The MRU QAC will recommend a referral to the Department of Health via the ORM Incident Reporting Unit.

Important Information

- The Mortality Review Unit can be reached by emailing: DDD.ORMmortality@dhs.nj.gov
- DIVISION CIRCULAR #14 (nj.gov) Reporting Unusual Incidents
- Incident Reporting Information: Division of Developmental Disabilities | Incident Reporting (nj.gov)