



COMMONWEALTH OF VIRGINIA
Office of the State Inspector General

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The Honorable Ralph Northam
Governor of Virginia
P.O. Box 1475
Richmond, VA 23219

Dear Governor Northam:

The Office of the State Inspector General (OSIG) conducted a review of mortality policies and procedures in facilities operated by the Virginia Department of Behavioral Health and Developmental Services (DBHDS), including Central Office. The goal of this review was to identify areas of improvement in reporting and reviewing patient deaths in DBHDS facilities. This was not a quality of care review, but rather a review of the policies and processes related to patient deaths and internal review thereof, as well as documentation of patient death reviews.

Background

DBHDS operates 13 facilities across the Commonwealth of Virginia: eight behavioral health facilities for adults, two training centers (one of which closed in fiscal year 2020), a psychiatric facility for children and adolescents, a medical center and a center for behavioral rehabilitation. State facilities provide highly structured, intensive services for individuals with mental illness and developmental disabilities or who are in need of substance use disorder services.

As mandated by the *Code of Virginia* § 2.2-309.1(1), OSIG will “provide inspections of and make policy and operational recommendations for state facilities and for providers, including licensed mental health treatment units in state correctional facilities in order to prevent problems, abuses, and deficiencies in and improve the effectiveness of their programs and services.”

As part of OSIG’s oversight and the Fiscal Year 2020 Annual Work Plan, OSIG identified DBHDS mortality review policies and procedures as an area to evaluate.

Scope

OSIG requested pertinent DBHDS Central Office Departmental Instruction(s) and pertinent policies and procedures from all 13 DBHDS facilities, as part of this review. In addition, OSIG requested 45-Day Death Summaries for 96 deceased patients whose date of death was between January 1, 2018, and June 30, 2019.

Review Methodology

As part of the review, OSIG conducted interviews with the following DBHDS staff:

- Acting Director, Eastern State Hospital
- Assistant Commissioner for Forensic Services
- Assistant Deputy Commissioner for Facility Services
- Behavioral Health Facility Operations Specialist
- Mortality Review (Developmental Disabilities) Clinical Coordinator
- Staff Nurse, Eastern State Hospital

Additional resources requested from DBHDS Central Office and facilities included, but were not limited to:

- Department Instruction (DI) 315 (QM) 13 “Reporting and Reviewing Unexpected Deaths”
- Department Instruction (DI) 401 (RM) 03 “Risk and Liability Management”
- “Sentinel Event Policy and Procedures,” The Joint Commission

Mortality review policies were requested from individual facilities. The facilities sent the following policies:

- Catawba Hospital
 - CHPP 05.32 “Medical Examiner’s Cases”
 - CHPP 8.03 “Disposition of Deceased Patient’s Body”
 - CHPP 8.14 “Social Work Family Contact”
 - CHPP 24.11 “Event Reporting/Sentinel Events”
 - Mortality Review Form
 - Policy No. 06.046 “Dying Patient, Special Considerations”
 - Policy No. 06.053 “Death of Patient, Handling Of”
- Central State Hospital
 - Uses Central Office DI’s (No Facility Specific Instruction)
- Central Virginia Training Center
 - Policy 118 “Mortality Review Committee”

- Commonwealth Center for Children and Adults
 - Uses Central Office DI's
- Eastern State Hospital
 - Policy No. 271-002 "Facility Event Reporting"
 - Policy No.450-040 "Death & Disposition of Deceased Patients"
 - Policy No. 050-057 "Reporting and Investigating Abuse and Neglect of Patients"
- Hiram Davis Medical Center
 - Instruction No. 5701.1A "Discharge/Death Summaries"
 - Instruction No. 5710.IN "Decedent Affairs"
- Northern Virginia Mental Health Institute
 - Policy No. E-11 "Sentinel Events"
 - Policy No. M-02 "Morbidity and Mortality Review"
- Piedmont Geriatric Hospital
 - "Criteria for Mortality Review Form"
 - DI No. 401 (RM) 03 "Risk and Liability Management"
 - Instruction No. 406 (RM) 17 "Patient Safety Events"
 - Instruction No. 409 (RM) 17 "Incident Reporting"
- Southeastern Virginia Training Center
 - Instruction No. 8205 "Mortality Review Committee"
 - Instruction No. 8200 "Death of an Individual"
- Southern Virginia Mental Health Institute
 - No. 310 (QM) 07/2019 "Mortality Case Review"
 - No. 403 (RM) 12/11 "Review and Reporting of Sentinel Events"
- Southwestern Virginia Mental Health Institute
 - Policy No. 3002 "Deaths Reporting to Medical Examiner, Autopsies"
 - Policy No. 11002 "Reporting and Follow-up of Facility Incidents"
- Virginia Center for Behavioral Rehabilitation
 - Instruction No. 409 "Death of a Resident and Post Mortem Procedures"
- Western State Hospital
 - Instruction No. 5101 "Sentinel Events"
 - Policy #39.01 "Medical Staff Peer Review Policy and Process"

Findings/ Corresponding Recommendations

FINDING #1:

DBHDS CENTRAL OFFICE AND FACILITIES LACK UNIFORM IDENTIFICATION OF PATIENT DEATHS TO RECEIVE POST-MORTEM REVIEW, RESULTING IN POTENTIAL LOSS OF OPPORTUNITY FOR IMPROVEMENT OF CARE.

According to the policies reviewed from each of the 13 DBHDS facilities, there is a lack of consistency in the types of deaths reviewed post-mortem. As shown in *Figure 1*, nine of the 13 facilities reviewed only unexpected deaths, while four facilities reviewed all deaths. These inconsistencies could potentially affect system-wide data collection, also contributing to the potential loss of opportunity for system improvement in quality of care. Rigorous inquiries to identify opportunities for system improvements that will reduce risks to individuals receiving services from DBHDS are only completed on “unexpected” deaths, according to DI 315 (QM) 13. Without at least minimal review of “all” deaths to confirm appropriate categorization, data could potentially be erroneously benchmarked.

Figure 1

According to Policy	Facility												
	CAT	CSH	CCCA	CVTC	ESH	HDMC	NVMHI	PGH	SEVTC	SVMHI	SWVMHI	VCBR	WSH
REVIEWS ALL DEATHS				✓			✓		✓	✓			
REVIEWS UNEXPECTED DEATHS ONLY	✓	✓	✓		✓	✓		✓			✓	✓	✓

According to an Office of Licensing memorandum (July 2019), “DBHDS will have a Mortality Review Committee to review deaths of patients receiving developmental disabilities (DD) services through DBHDS licensed providers. This committee is established by the Commissioner and led by the Medical Director/Chief Clinical Officer and conducts monthly reviews of all expected and unexpected DD deaths reported in the incident reporting system (CHRIS). The purpose of the review is to identify trends, patterns, and problems at the individual service-delivery and systemic levels that may have resulted in or contributed to the death, and implement quality improvement initiatives to reduce mortality rates to the fullest extent practicable.”

RECOMMENDATION #1:

A. Regardless of classification, the DBHDS Commissioner should ensure that a medical review is conducted on all deaths as shown in *Figure 2* by a Facility Medical Director selected by the Chief Clinical Officer. This process should be completed timely since the medical review

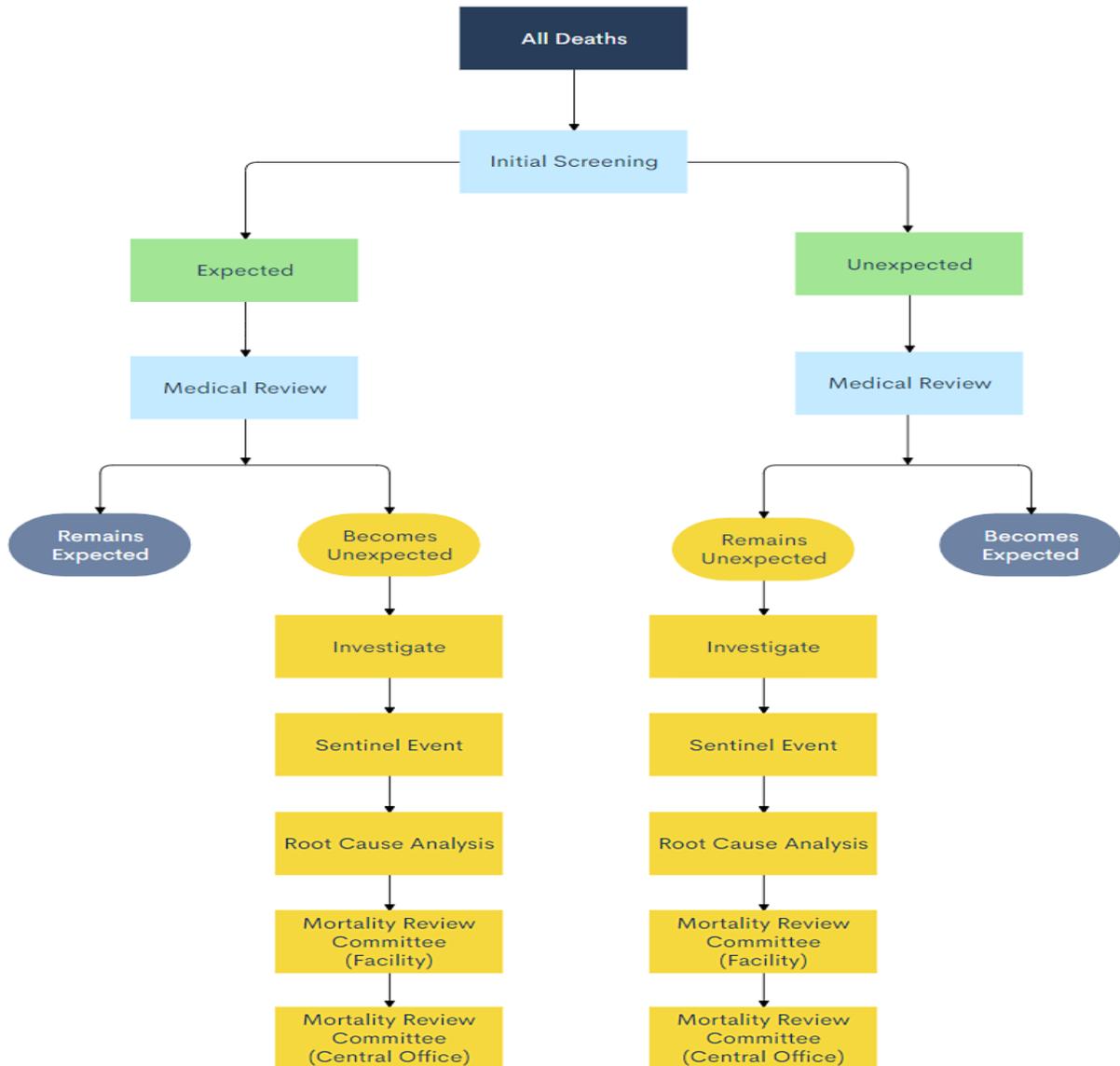
could potentially determine that an expected death may require reclassification as unexpected and warrant further investigation. The following deaths should be included:

1. All deaths occurring in DBHDS facilities.
2. Deaths occurring 21 days after discharge.
3. Deaths occurring during special hospitalization.

B. Those deaths deemed “unexpected” should receive a more rigorous review to determine if adequate care was administered prior to death.

C. BHDS should update DI 315 (QM) 13 to reflect the change and all facilities shall update their policies to reflect the same language.

Figure 2



DBHDS Response:

- A. *DBHDS has established a Facility Mortality Review (FMR) process (including revision of DI 315) whereby all facility deaths will be reviewed by DBHDS Central Office (CO) effective July 1, 2020. This process includes deaths occurring within 21 days after discharge when known and for patients that have not been discharged while receiving care by another provider.*
- B. *As is current practice and documented in the revised DI 315, the DBHDS Facility Mortality Review Committee (FMRC) will review all facility deaths (including unexpected) to examine the circumstances leading up to the individual's death, including systemic, provider, and individual factors around the care of the individual. The FMRC will make recommendations, as applicable and warranted, in order to reduce mortality rates to the fullest extent practicable for every resident in our state facilities.*
- C. *DBHDS has revised DI 315, which is currently under review by the Office of the Attorney General. Once approved and implemented, DBHDS facilities will update their policies.*

FINDING #2:

THE FACILITY MORTALITY REVIEW PROCESS LACKS OVERSIGHT FROM THE DBHDS CENTRAL OFFICE.

In accordance with DBHDS staff interviews, OSIG was informed that an active Central Office Mortality Review Committee (MRC) no longer exists. DBHDS was unable to provide meeting minutes to demonstrate the previous existence of the MRC. This committee served as a second level of oversight review for the facility MRCs and tracked the implementation of recommendations for improvement of care. However, a Central Office MRC exists for the sole purpose of reviewing deaths that occurred in DBHDS-licensed Developmental Disabilities Community Providers.

In addition to the absence of this committee, the current Central Office Departmental Instruction has not been updated to reflect the lack of Central Office mortality review oversight.

Completing a full assessment of a patient's death is the purpose of the mortality review process in order to determine if a patient received adequate care and appropriate measures were taken to prevent premature death. Collection and trending of data can help determine if systemic issues exist and what, if any, remedial or preventative steps could be implemented to mitigate future risks. Remediation may include, but not be limited to, staff training, revisions of policy, environmental issues, equipment deficiencies, and medical assessment or treatment.

The Central Office DI (dated 2013) refers to a data collection system that will be implemented to trend and track systemic failures resulting in deaths in the facilities. It is unclear when this system will be put into place. OSIG has not been notified of implementation.

RECOMMENDATION #2:

- A. DBHDS should establish a Central Office MRC to review, benchmark and track deaths occurring in the facilities. This committee should be responsible for providing system-level and facility recommendations to mitigate risk, prevent death and improve quality of care. This committee should include stakeholders with expertise, both internal and external.
- B. This committee should record minutes of the meetings, including recommendations. DBHDS should follow up with each facility to ensure those recommendations have been appropriately implemented.
- C. DBHDS should implement a data collection system to trend and track systemic failures in quality of care and ensure implementation of recommendations.

DBHDS Response:

- A. *DBHDS has established a FMR process, which includes a DBHDS FMRC. The revised DI 315 describes and defines data review, analysis and development of quality improvement recommendations, as well as FMRC responsibilities and membership.*
- B. *DBHDS will implement and utilize the current I/DD MRC documentation process, including meeting minutes format, for the FMRC to ensure consistency and follow-up.*
- C. *DBHDS recently enhanced the system-wide incident tracker, and is exploring other related system enhancements and implementation of the new electronic health record system. We anticipate these enhanced system capabilities will address the needs of the FMRC, but will continue evaluating solutions for any needs beyond the capability of these systems if necessary.*

FINDING #3:

CENTRAL OFFICE DEPARTMENTAL INSTRUCTIONS AND FACILITY POLICIES AND PROCEDURES ARE NOT REVIEWED AND/OR UPDATED ON A REGULAR BASIS.

Central Office and the facilities submitted DIs and policies as requested. However, as shown in *Figure 3*, Central Office and seven facilities have at least one policy that has not been reviewed in several years.

With Central Office DIs being the foundation on which the facilities should base their policies and procedures, DBHDS should oversee review and revision on a regular basis to ensure guidance is effective and efficient. Facilities should also review and update policies and procedures at regular intervals as directed through guidance by Central Office. It is DBHDS

Central Office’s responsibility to ensure that individual facility policies are consistent and reflect the instruction set forth by DBHDS.

According to 12VAC5-371-140, other state agencies are required by the *Code of Virginia* to review their policies and procedures at least annually. This represents a best practice for other state agencies. Policies relating to higher risk areas may need review more often than those more generalized or lower risk areas and help to ensure compliance with existing regulations and the most current technology.

Figure 3



RECOMMENDATION #3:

- A. DBHDS Central Office should develop and implement a DI regarding regular review of policies and procedures for DBHDS facilities. This review should occur at least annually, with revision recommendations as needed according to identified risk and current regulations and standards.
- B. DBHDS Central Office should provide oversight to the facilities to ensure consistency in policies and procedures regarding mortality review in alignment with the Central Office DI.
- C. DBHDS Central Office should provide oversight to the facilities to ensure review and/or revision of policies are completed in a timely manner as set forth in the DI.

DBHDS Response:

- A. DBHDS will develop a new policy or revise the Development of Department Instructions DI 807, to include requirements for the review of facility policies and procedures.*
- B. DBHDS will provide oversight to ensure facilities align their policies and procedures to be consistent with the revised DI 315.*
- C. DBHDS will provide oversight to ensure facilities complete policy review requirements timely.*

FINDING #4:

DBHDS DOCUMENTATION OF DEATHS LACK CONSISTENCY, DETAILS, ACCURATE REPORTING, AUTHOR SIGNATURES, AND DATES OF COMPLETION.

The Central Office DI requires a 45-Day Death Summary for all unexpected deaths. This summary is, “A factual summary of important developments leading to the death. The factual summary shall include:

- A list of current diagnoses and active medical problems at the point the episode began to develop.
- The interventions, medications, and treatment related to the active medical problems at the point.
- Key developments in the course of the illness leading to the death that include signs, symptoms, tests, exam findings, treatment provided, response to treatment, and information related to family contact and decision making.”

OSIG, to date, reviewed 42 of the 45-Day Death Summaries requested and identified 17 summaries (40 percent) that contained significant spelling and grammatical errors that materially affected the content of the document. OSIG noted that all errors were on summaries provided by Eastern State Hospital.

OSIG also noted that the author did not sign or date the documents. Of the 42 45-Day Death Summaries reviewed, 25 (60 percent) were not signed. OSIG noted that:

In 2018:

- 13 at ESH were not signed
- 5 at SWVMHI were not signed

In 2019:

- 6 at ESH were not signed
- 1 at WSH was not signed

According to DBHDS Licensing Regulation 12VAC35-105-880, “Entries in the individual’s record shall be current, dated, and authenticated by the persons making the entries.” This signature ensures there is a reference for future questions regarding the documentation and assigns ownership to the document.

Additionally, OSIG noted that when requesting 45-Day Death Summaries, facilities provided both the 45-Day Death Summaries and meeting minutes depending on the facilities. OSIG noted that when reviewing the minutes provided (in lieu of the actual summary) multiple patients were included in one single document.

Per HIPPA guidelines, each patient’s information should be documented separately within the recorded minutes. This ensures that once the information is recorded and stored, individuals with approved access to one file are not provided access to multiple patient’s information for which they do not have approval.

RECOMMENDATION #4:

OSIG recommends that the DBHDS Commissioner:

- A. Implement a quality review process to review and edit 45-Day Death Summaries for spelling and grammatical errors, which could potentially change the interpretation of the document.
- B. Ensure through the quality review process that the 45-Day Death Summary includes an accurate depiction of the patient’s status and/or change thereof, events leading up to the death, and the actions that took place after the discovery of the body.
- C. Ensure through the quality review process that all documents include accurate identifying information.
- D. Document patient’s information separately within the Mortality Review Committee Meeting Minutes.
- E. Ensure all patient documentation is signed and dated by the author.

DBHDS Response:

- A. *DBHDS will provide oversight to ensure facilities complete policy review requirements timely.*
- B. *A form for facilities to utilize when developing 45-day reports is part of the revised DI 315. The form was developed to account for events leading up to the death as well as post mortem actions taken. If the accuracy of events needs to be clarified, the morality review team will reach out to the facility to evaluate the circumstances of the death further.*

- C. *If identifying information appears to be inaccurate during the review process, the morality review team will reach out to the facility to clarify or receive additional information as deemed necessary.*
- D. *Mortality Review documents are not released to the public, nor stored in patient charts - they are for members to review only during closed, confidential meetings. Thus, it is not a breach of HIPAA for the mortality review committee minutes to contain documentation of multiple cases. No other individual has or will be granted access to MRC meeting minutes, unless specifically listed in the Code of Virginia.*

Specific details relevant to mortality reviews are located in Chapter 3 of Title 37.2 in the Code of Virginia and are referenced here:

17. Any operating procedures for review of child deaths developed by the State Child Fatality Review Team pursuant to §32.1-283.1, any operating procedures for review of adult deaths developed by the Adult Fatality Review Team pursuant to §32.1-283.5, and any operating procedures for review of adult deaths developed by the Maternal Mortality Review Team pursuant to §32.1-283.8, and any operating procedures for review of the deaths of persons with a developmental disability developed by the Developmental Disabilities Mortality Review Committee pursuant to §37.2-314.1.

All information obtained or generated by the Committee or on behalf of the Committee regarding a review shall be confidential and excluded from the Virginia Freedom of Information Act (§2.2-3700 et seq.) pursuant to subdivision 7 of §2.2-3705.5. Such information shall not be subject to subpoena or discovery or be admissible in any civil or criminal proceeding. The findings of the Committee may be disclosed or published in statistical or other form but shall not identify any individuals if so disclosed or published. The portions of meetings in which individual death cases are discussed by the Committee shall be closed pursuant to subdivision A 21 of §2.2-3711. In addition to the requirements of §2.2-3712, all members of the Committee and other persons attending closed meetings of the Committee, including any persons presenting information or records on specific deaths, shall sign an agreement to maintain the confidentiality of the information, records, discussions, and opinions disclosed during meetings at which the Committee reviews a specific death.

- E. *The author's signature and date are required elements of the form facilities will utilize to develop 45-day reports. If those fields are not completed, the FMRC will request the facility to update the record accordingly.*

On behalf of OSIG, I would like to express our appreciation to DBHDS Commissioner Alison Land and her staff within Central Office as well as facility directors during this review.

Respectfully,

7/27/2020

X Michael C. Westfall

Michael C. Westfall, CPA

State Inspector General

Signed by: Westfall Michael wzg39453

cc: The Honorable Clark Mercer, Chief of Staff to Governor Northam
The Honorable Daniel Carey, M.D., Secretary of Health and Human Resources
The Honorable Senator George L. Barker (Interim) Chair, Joint Commission on Health Care
Alison Land, Commissioner, DBHDS
Heidi Dix, Deputy Commissioner, Quality Management & Government Relations, DBHDS
Angela Harvell, Deputy Commissioner, Facilities, DBHDS
Alvie Edwards, Asst. Commissioner for Compliance, Risk Management & Audit, DBHDS