CF OPERATING PROCEDURE
NO. 155-3

STATE OF FLORIDA
DEPARTMENT OF
CHILDREN AND FAMILIES
TALLAHASSEE, July 9, 2019

Mental Health/Substance Abuse

STATE MENTAL HEALTH TREATMENT FACILITIES MORTALITY REPORTING AND REVIEW PROCEDURE

1. Purpose. The purpose of this operating procedure is to provide guidelines for reporting and conducting an internal review of the death of residents served in state mental health treatment facilities. The intent of the review process is to assess service provision, identify opportunities for service enhancements, and to aid in reducing the incidence of illness and death.

2. Scope. Guidelines described in this operating procedure apply to all state operated and contracted mental health treatment facilities serving residents committed to the department pursuant to Chapter 394, Florida Statutes (F.S.), or Chapter 916, F.S., including the Florida Civil Commitment Center.

3. References.

a. Chapter 394, F.S., Part I: Florida Mental Health Act, Section 394.457, Operation and administration.

b. Chapter 406, F.S., Medical Examiners: Disposition of Dead Bodies; Section 406.11, Examinations, investigations, and autopsies; Section 406.12, Duty to report; prohibited acts.

c. Chapter 872, F.S., Offenses concerning dead bodies and graves; Section 872.04, Autopsies, consent required, exception.

d. Chapter 916, F.S., Mentally deficient and mentally ill defendants; Section 916.1093, Operation and administration; rules.

e. Chapter 11G-2, Florida Administrative Code (F.A.C.), Standard investigation procedures, Rule 11G-2.003, Investigation.

f. Chapter 59A-10, F.A.C., Internal Risk Management Program, Rule 59A-10.0055, Incident Reporting System.

g. Constitution of the State of Florida as Revised in 1968 and Subsequently Amended, Article 10, Section 25, page 36, Patients' right to know about adverse medical incidents.

h. Code of Federal Regulations Title 42, Public Health, Part 482: Conditions of Participation for Hospitals; Subpart C: Basic Hospital Functions; Section 22: Condition of participation: Medical Staff; Subsection (d): *Standard: Autopsies*.

i. Code of Federal Regulations Title 42, Public Health, Part 51: Requirements Applicable to the Protection and Advocacy for Individuals with Mental Illness; Subpart D: Access to Records, Facilities, and Individuals, Section 51.41: Access to Records.

j. Public Law 104-191: Health Insurance Portability and Accountability Act of 1996.

This operating procedure supersedes CFOP 155-3 dated June 15, 2015.
OPR: SMF
DISTRIBUTION: OSGC; ASGO; Regional Directors; Region circuit Mental Health Treatment Facilities

k. Commission on Accreditation of Rehabilitation Facilities (CARF), Behavioral Health Standards Manual, 2013.

l. The Joint Commission: *Comprehensive Accreditation Manual for Hospitals,* 2019.

4. Definitions. For the purposes of this operating procedure, the following terms shall be understood to mean:

a. Adverse Incident. An event over which health care personnel could exercise control, and which is associated in whole or in part with medical intervention, rather than the condition for which such intervention occurred, and which results in serious injury or death.

b. Death of a Resident. The end of a resident's life while admitted to a state mental health treatment facility or within thirty (30) days of discharge from the facility if the death becomes known to the facility. The manner of death explains how the death occurred. The manner of death may be:

(1) Accident. Due to unintended actions. This is determined by a medical examiner.

(2) Homicide. Due to the deliberate actions of another. This is determined by a medical examiner.

(3) Natural Expected. A death that occurs as a result of, or complications of, a diagnosed illness for which the prognosis is terminal.

(4) Natural Unexpected. A sudden death that was not anticipated and is attributed to an underlying disease either known or unknown prior to the death.

(5) Suicide. The intentional and voluntary taking of one's own life as determined by a medical examiner.

(6) Undetermined. The cause of death was not determined following completion of an autopsy by a medical examiner.

(7) Unknown. The cause of death is not known. This may change from unknown pending autopsy findings.

c. Department. The Department of Children and Families.

d. Facility Incident Tracking System (FITS). An electronic database for state mental health treatment facility reporting (SMHTF) reporting of resident deaths and other reportable incidents.

e. Mortality Review. An objective assessment of the service provision and circumstances surrounding the death of a resident to consider if all necessary and reasonable measures were taken to ensure the resident's health and safety. The mortality review committee will review the clinical services goals and outcomes to determine if the recovery or treatment plan met the resident's needs, facility policies, protocols, and professional standards of care and to identify any missed opportunities for service provision or ways future service provision at the facility could be improved.

f. Mortality Review Committee. An interdisciplinary committee convened by the Medical Executive Director or physician designee that includes the recovery team and administrative and quality improvement staff as needed to conduct the review.

g. Psychological Autopsy. A procedure for investigating a suicide by reconstructing what the person thought, felt, and did prior to his or her death.

h. Root Cause Analysis (RCA). A retrospective, structured review and analysis of data pertaining to a sentinel event by an interdisciplinary team. The review includes a process for identifying contributing/causal factors that underlie variations in performance associated with the sentinel event. The process asks the questions: what happened; why it happened; and what should be done to prevent it from happening again. An RCA provides a systems approach to prevention that is used to build a "culture of safety" and includes a process for measuring and tracking outcomes.

i. Root Cause Analysis Committee. An administrative/professional committee appointed by the Clinical Director in conjunction with the Hospital Administrator to conduct a root cause analysis of a sentinel event. At a minimum, the committee will include:

(1) The Medical Executive Director or physician designated to chair the committee;

(2) The Medical, Nursing, and Pharmacy Directors;

(3) Other clinicians and professional staff as designated by the Medical Executive Director based on the circumstances surrounding the sentinel event; and,

(4) The Facility Administrator or designee, Quality Improvement Director, Risk Manager, and Facility Attorney.

NOTE: *The root cause analysis committee members may be the same or may include the same members as the mortality review committee, but the committee members must keep the two processes separate and distinct.*

j. Sentinel Event. For purposes of this operating procedure, a sentinel event means any unanticipated event in a healthcare setting resulting in death, not related to the natural course of the resident's illness. This includes all suicides and homicides.

k. Terminal Illness. A diagnosed condition for which there is no known cure and the prognosis is expected to be fatal.

5. General.

a. Death is a natural part of the life cycle. The department supports the review of deaths as an integral component of continuous quality improvement. Completion of a mortality review following each death and a root cause analysis following a sentinel event supports recognized standards of practice, risk management, resident safety, and accident prevention. The purpose of these reviews is not to assess clinical competence or to determine a violation of residents' rights, rules, or regulations. These issues are addressed through other administrative means identified by professional licensure boards, state laws, and facility policy.

b. There are residents in the treatment facilities who suffer from illnesses that predispose them to sudden death and others who are suffering from illnesses of a terminal nature. In these instances, death is considered natural. The mortality review of a natural expected death will focus on adherence with the resident's wishes if identified in an advance directive. The review will examine the course of treatment including palliative care, pain management, and support for the resident and family members as they make end of life decisions.

c. Clinical staff will assist and support grieving residents in the facility, staff, or family members as the review process is conducted.

d. If an employee is being investigated in relation to a resident death, the employee shall be placed on a mandatory two (2) days of Administrative Leave with Pay. Additional Administrative Leave

with Pay may be imposed by the Secretary or an authorized representative of the Secretary. The maximum Administrative Leave with Pay shall not exceed 20 work days, unless additional Administrative Leave with Pay is imposed at the request of the Secretary or authorized representative of the Secretary. In addition, the employee shall be referred to the Employee Assistance Program. The servicing Human Resources office should be contacted to assist with placing the employee on administrative leave in accordance with rules and policies.

6. Procedure for Reporting a Death.

a. The medical examiner will be notified of all deaths pursuant to Chapter 11G-2, F.A.C. A full autopsy will be completed pursuant to Section 406.11, F.S., as determined by the medical examiner.

b. For other than natural deaths, law enforcement will be immediately notified.

c. A resident death resulting from suicide, homicide, accident, or an unknown or undetermined cause is a critical event and should be reported consistent with CFOP 155-25, Incident Reporting and Processing in SMHTFs, within one (1) hour by phone to the Chief Hospital Administrator or designee. If the Chief Hospital Administrator or designee is unavailable, a call should be made to the Assistant Secretary for Substance Abuse and Mental Health. Verbal contact must be made with one of these individuals. Notice should also be sent via email to the department's Director of Communications.

d. Notification of Death shall be entered in FITS by the next working day.

e. Facilities that are licensed as a hospital pursuant to Chapter 395 F.S. by the Agency for Health Care Administration (AHCA) must report all adverse incidents pursuant to s. 395.0197, F.S.

(1) Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident through the Agency's Adverse Incident Reporting System (AIRS) which can only be accessed through the Agency's Single Sign On Portal located at http://ahca.myflorida.com/SCHS/RiskMgtPubSafety/RiskManagement.shtml.

(2) A copy of the completed form submitted through the AHCA AIRS reporting system shall be emailed within 15 days of death to the Registered Nursing Consultant in the Substance Abuse/Mental Health Program Office at HQW.RNConsultant@myflfamilies.com.

f. Reporting Deaths Related to Restraint and Seclusion Events.

(1) The facility will report any death that occurs while a resident is restrained or in seclusion within 24 hours after a resident has been removed from restraint or seclusion, or within one week after restraint or seclusion where it is reasonable to assume that the use of restraint or placement in seclusion contributed directly or indirectly to a resident's death. Deaths related to restriction of movement for prolonged periods of time, chest compression, restriction of breathing or asphyxiation are causes of death to consider in the context of "reasonable to assume".

(2) If the facility is licensed as a hospital pursuant to Chapter 395, F.S. and is providing services to Medicare or Medicaid beneficiaries, reporting must be consistent with the federal regulation, Title 42 CFR 482.13(g). Hospitals must use Form CMS-10455, "Report of a Hospital Death Associated with Restraint or Seclusion," to report deaths associated with restraint and/or seclusion that are required by 42 CFR §482.13(g) to be reported directly to the CMS Regional Office. The form may be downloaded from the following webpage: http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS10455.pdf.

(3) Under 42 CFR §482.13(g), hospitals must report the following deaths associated with restraint and seclusion to the CMS Regional Office no later than the close of business on the next business day following knowledge of the patient's death:

(a) Each death that occurs while a patient is in restraint or seclusion, excluding those in which only 2-point soft wrist restraints were used and the patient was not in seclusion at the time of death;

(b) Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion, excluding those in which only 2-point soft wrist restraints were used and the patient was not in seclusion within 24 hours of their death; and,

(c) Each death known to the hospital that occurs within one week after restraint or seclusion where it is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to a patient's death, regardless of the type(s) of restraint used on the patient during this time.

(4) Hospitals must record in an internal hospital log or other system deaths that occur in the following circumstances listed below. The log must include the information specified at 42 CFR §482.13(g)(4)(ii) and the log entry must be made no later than seven days after the date of death of the patient. Hospitals should not send reports of these deaths to the Regional Office:

(a) Each death that occurs while a patient is in restraint but not seclusion and the only restraints used on the patient were applied exclusively to the patient's wrist(s) and were composed solely of soft, non-rigid, cloth-like materials; and,

(b) Each death that occurs within 24 hours after the patient has been removed from restraint, when no seclusion has been used and the only restraints used on the patient were applied exclusively to the patient's wrist(s) and were composed solely of soft, non-rigid, cloth-like materials.

(5) Death and restraint form CMS-10455 should be emailed to FL_DeathReports@cms.hhs.gov or faxed to (443) 380-5912. Questions regarding these instructions should be directed to Jackie Whitlock at Jacqueline.whitlock@cms.hhs.gov or 404-562-7437. Staff must document in the resident's medical record the date and time the death was reported to CMS.

g. The reporting of deaths that are sentinel events will occur if required by the organization that grants accreditation.

h. All deaths that occur at the Florida Civil Commitment Center (FCCC) shall be reported directly to the Sexually Violent Predator Program Director.

7. Staff Responsibilities at the Time of a Resident's Death. For all unexpected deaths:

a. A unit supervisor will interview staff who were attending to the resident on the shift when the death occurred. All progress notes of the event that occurred through the disposition of the body will be recorded at the time of the event or prior to the staff leaving the unit for that shift. Late entries should not occur in the event of a resident death. Debriefing of staff and residents who witnessed the event will be initiated within 24 hours of the death.

b. The attending physician or Medical Executive Director should obtain consent from the family if the family requests an autopsy be completed and the medical examiner has declined to do an autopsy. The Medical Executive Director may request consent for an autopsy from the resident's representative if he or she feels the death is of medical or legal interest. The purpose and benefit of

completing a full or partial autopsy will be discussed with the representative. The medical staff, and specifically the attending practitioner, will be notified by the Medical Executive Director when an autopsy is being performed.

c. Consent from the family or legal representative may be obtained in writing from:

(1) The health care surrogate, as provided in s. 765.202, F.S., if one has been designated.

(2) If a health care surrogate has not been designated, consent may be provided by the spouse, nearest relative, or, if no such next of kin can be found, the person who has assumed custody of the body for purposes of burial. When two or more persons assume custody of the body for such purposes, then the consent of any one of them is sufficient to authorize an autopsy.

(3) Consent may be given by telegram and any telegram claiming to have been sent by a person authorized to give such consent will be presumed to have been sent by such person.

(4) A duly witnessed telephone permission is acceptable in place of written permission in those circumstances where obtaining written permission would result in undue delay.

(5) Documented consent for an autopsy will be filed in the legal section of the deceased's medical record. The physician who obtained consent and the staff witness will both sign the consent form in the case of consent obtained over the telephone. The physician will document the name of the person providing the consent and the person's relationship to the deceased on the form.

d. If no family member is available to provide consent, the chief law enforcement officer who has jurisdiction must conduct a thorough examination of missing persons records and other inquiry to determine that no person can be found who can authorize an autopsy before an autopsy can be completed without consent. The reasonable time for thorough search and inquiry is considered not less than 48 hours or more than 72 hours after death. The facility Medical Executive Director can order an autopsy in absence of consent for purposes of confirming medical diagnosis and suspected communicable diseases following law enforcement inquiry. The autopsy must be conducted by a physician whose practice involves the usual performance of autopsies.

8. The Mortality Review Process.

a. The clinical record of a decedent is to be secured immediately after death to ensure no changes, additions, or deletions occur prior to the mortality review or root cause analysis.

b. Mortality reviews will be conducted by the Medical Executive Director or physician designee within thirty days of a death as defined in facility policy. Mortality review meetings are confidential and not open to the public because of the protected health information that is discussed.

c. Each facility will review the death of:

(1) Each resident that dies at the facility;

(2) Residents transferred from facilities to receive care in other settings (such as acute care medical hospitals);

(3) Residents on any type of leave status from the facility; and,

(4) Residents known to have expired within thirty calendar days of discharge. All attempts to obtain information regarding the death will be documented.

d. Staff providing services directly to the resident will participate in the review but will not chair the meeting nor oversee the review.

e. The review of the resident's medical (clinical) record will begin as soon as possible but no later than three working days following the death.

f. All clinical disciplines that provided services to the resident during the six months prior to his/her death (or from the date of admission if less than six months) will document a discharge summary including a review of the services provided, progress of the resident's behavioral and physical health conditions, and events that occurred leading up to the resident's death.

g. The mortality review will provide a retrospective review of resident assessments, treatment formulations, service provision and resident outcomes. The review will include the preliminary medical examiner ruling as to the manner and cause of death (if the death is a medical examiner's case), and a collaborative, clinical discussion of the circumstances that led to the death.

h. The mortality review report will contain an integrated summary of the resident's course of care during hospitalization, progress or lack of progress with services provided, events leading up to the resident's death, and the committee's findings related to opportunities for improvements. An action plan will be developed if service enhancements are identified.

i. The Registered Nursing Consultant at the Program Office shall be notified one week in advance of the date and time of the mortality review meeting and provided an opportunity to participate by phone or in person. This notification should be by email to HQW.RNConsultant@myflfamilies.com.

9. The Root Cause Analysis (RCA) Process.

a. Data is collected through interview, document review, and observation. The data collected is utilized to generate a sequence or timeline of events preceding and following the death. The goal of the data analysis will be to determine common underlying factors about how and why the death happened and to identify potential improvements in processes or systems that would tend to decrease the likelihood of such an event occurring for the same reason. It may also be determined after analysis that no improvement opportunities exist.

b. The RCA format is at the discretion of the facility's Medical Executive Director.

c. The RCA will be completed within 45 days of the event.

d. The RCA report will identify the root cause(s) of the sentinel event through evidence-based investigation and thoughtful analysis that is supported by relevant literature. To be thorough, the RCA will include inquiry; identify risk points; determine human and other factors directly associated with the event; and analyze the underlying processes or systems.

e. Any conditions found that increase the risk of adverse consequences will be targeted with process revisions. The action plan will identify the strategies that the facility will implement in order to reduce the risk of a similar event occurring in the future. The newly identified process will address responsibility for implementation, oversight, time lines, and strategies for measuring the effectiveness of the actions.

10. Suicide and the Completion of a Psychological Autopsy.

a. The intent of the psychological autopsy is to attempt to discern the resident's state of mind at the time of death, to find the requisite intent for suicide or, in the alternative, that there is an absence of evidence indicating suicide.

b. The information for the psychological autopsy will be obtained by interviewing individuals who knew the victim well enough to report on his/her actions, behaviors, and character. Interviews will be conducted in such manners that will provide some therapeutic value for survivors. Medical records will be reviewed, along with the events leading up to the person's death, and the official account of the death. Other information reviewed may include, but is not limited to, physical autopsy results, police reports, and facility records.

c. In an unclear case, it may be difficult to evaluate the resident's intentions either because the factual circumstances of the death are lacking or because the resident's intentions were incomplete, inconsistent, or not clear. The review team will attempt to identify the factors contributing to the suicide decision for future assistance for staff regarding early identification of risk factors and behavioral patterns that accompanies different degrees of suicidal intent.

d. Psychological autopsies will be conducted by a licensed psychologist and will typically include: identifying information (demographics); a summary of the key facts in the case including reviews and events surrounding the suicide; a developmental history; a family history; a description of treatment and personal history; the diagnostic formulation; and any recommendations.

11. Recordkeeping.

a. A mortality file labeled "RISK MANAGEMENT CONFIDENTIAL INFORMATION" will be maintained per facility policy. The file will contain the final written reports based on the reviews completed following the death (mortality review report, root cause analysis report, and the psychological autopsy).

b. Medical records and mortality files will be maintained for at least seven years after the death.

12. Reports and Confidentiality.

a. When the death of a resident is the result of a sentinel event, the facility will complete both a mortality review and a root cause analysis. Reports of the committees' reviews and outcomes of their findings will be documented.

b. The Health Insurance Portability and Accountability Act of (HIPAA) of 1996 includes a person's right to privacy of protected health information that continues after the resident's death.

c. Mortality review, root cause analysis, and psychological autopsy reports will be maintained strictly confidential and retained in a designated, secured area in the facility. These reports will be available at the facility as allowed by HIPAA for review by Department associates, contractual associates, and licensure oversight. Examples of associates include but are not limited to:

(1) The Substance Abuse/Mental Health Program Office for contract and service provision monitoring at the facility.

(2) The Agency for Health Care Administration for risk management and licensure surveys.

d. Mortality review and root cause analysis reports will be available for review when authorized by the decedent's legal representative or by court order. An example of a group requiring consent to review protected health information is Disability Rights Florida pursuant to 42 U.S.C. 10806(b)(3), when Disability Rights is investigating an incident of potential abuse or neglect that was reported to them or if there is probable cause to believe that an incident of abuse or neglect occurred.

e. The release of a mortality review report, root cause analysis report, or psychological autopsy will require authorization from the facility or corporate attorney upon review of each request or court order for the information. Every page of these reports if required by law to be copied will be stamped "Privileged and Confidential Information – DO NOT COPY".

f. As directed in Article 10, Section 25 of the Florida Constitution, individuals who have received, are receiving, or have been referred to receive treatment in a facility may request facility reports related to adverse incidents. The facility attorney will review all requests for information. If a mortality review report, root cause analysis or other requested information meets the criteria for access based on the constitution, the individual will be notified and will be informed of the fee for staff locating, copying, and redacting information on all the reports/information requested. Requests will be processed in a timely manner once appropriate fees have been collected. The facility's risk manager or designee will obtain the reports/information and ensure all protected health information and the names of committee members have been redacted prior to providing the reports/information.

13. Quality Improvement.

a. Implementation and follow up of planned actions will be addressed as per facility policy.

b. The facility's Medical Executive Director will submit a summary of the mortality review and the root cause analysis, if a root cause analysis has been completed, to the Facility Administrator within 45 days following the death. If information from external sources is pending, the outstanding information will be noted. When outstanding information is received, the Medical Executive Director will review the information, date and sign it, and provide an addendum to the mortality review report. The Medical Executive Director will initiate any actions or reconvene the mortality review committee if either is determined to be needed. Any additional information or planned actions will be noted and filed in the mortality file.

c. The Facility Administrator will report the summary of findings to the facility's Governing Board at their next meeting (if the facility has a Governing Board), and to designated staff in the Substance Abuse/Mental Health Program Office. The Facility Administrator will notify the Chief Hospital Administrator or designee and Director of Policy and Programs when service enhancements have been completed.

d. The State Mental Health Treatment Facilities Director of Policy and Programs or the Chief Hospital Administrator may ask for an external review of the incident. Program Office staff may request notification of the date and time of the mortality review committee meeting, review the resident's medical record, and attend the mortality review meeting.

BY DIRECTION OF THE SECRETARY:

(Signed original copy on file)

WENDY SCOTT
Director, State Mental Health Treatment Facilities, Policy and Programs

SUMMARY OF REVISED, DELETED, OR ADDED MATERIAL

Updated all references in paragraph 3. Changed the label of paragraph 4a to Adverse Incident to be consistent with AHCA definition; added definition of Facility Incident Tracking System in paragraph 4d; changed definition in paragraph 4i (formerly paragraph 4h) to be consistent with Joint Commission definition; updated definition in paragraph 4j (formerly paragraph 4i); revised the reporting requirements in paragraph 6c for reporting a resident death; changed paragraph 6d to require reporting in FITS, and form CF-MH 1033 will no longer be used; changed paragraph 6e to reflect current AHCA reporting requirements, and to require that a copy of each adverse incident report submitted to AHCA be emailed to the Registered Nurse Consultant in the Program Office; revised paragraph 6f to reflect updated procedures for reporting to CMS deaths related to restraint or seclusion events; added paragraph 6h to clarify reporting requirements for the Florida Civil Commitment Center; added paragraph 8i requiring email notification to the Registered Nurse Consultant of a mortality review meeting; and the term “Clinical Director” was replaced by the term “Medical Executive Director” throughout the operating procedure