Promoting a Community of Safe Practice with a Focus on Prevention

The Office for People With Development Disabilities (OPWDD) implemented its mortality review process in partnership with the University of Massachusetts Center for Developmental Disabilities Evaluation and Research (CDDER), which consists of a Central Mortality Review Committee (CMRC) and six Local Mortality Review Committees representing regions statewide.

The mortality review process provides an expert review of potentially preventable deaths, identifies system issues that increase the risk of mortality and proposes solutions to improve the quality of supports and services across the system.

As part of its charge, OPWDD's CMRC seeks to inform the provider community of trends and risk factors to increase awareness with the ultimate goal of promoting and enhancing safe practices across the field. The purpose of this toolkit resource is to:

- Identify trends, risk factors and types of issues impacting the field, that were found through mortality case review in order to focus on best practice and prevention;
- Utilize case studies to demonstrate how circumstances can lead to an adverse event and what provider agencies can do to reduce the likelihood of these situations from occurring.

Trends and Risk Factors

OPWDD has issued Health and Safety Alerts addressing important risk factors and identifying actions that providers can proactively take to ensure the safety of the individuals we serve.

Ensuring Staff Know the Proper Procedure in a Medical Emergency

The key to swift action in a medical emergency is ensuring that staff know what to do and whom to call. The CMRC has found trends in case review regarding communication between direct support and clinical staff. Accordingly, OPWDD released the Telephone Triage Safe Practice Advisory: Telephone Triage for Timely and Effective Communication in an effort to provide guidance to the field regarding best practice for nurse triage based on central and local MRC recommendations and findings.

The guidance is written for providers and administrators who must operationalize the requirement for 24/7 nurse availability within Administrative Memo (ADM) 2013-01 and for the nurses who seek to incorporate evidence-based procedures within their professional practice to improve safety for individuals supported. In addition, direct support staff should always be empowered to call 911.

Transporting Individuals Safely in the Community and Vehicle Safety

OPWDD released an updated alert on Vehicle Safety. Revisions include advisement to carry-over dining safeguards to non-traditional settings related to cases involving choking in a van and aspiration at a picnic.

Additional revisions include advisement on management of health changes of individuals during transportation. This directly relates to a mortality case where staff were driving unsafely (i.e., speeding and not halting for traffic signals) and endangering themselves and others in seeking help rather than following proper procedure.

In the opinion of the CMRC, these circumstances highlight that provider agencies need to ensure that staff have appropriate training/policy to identify the proper actions to take in responding to a medical emergency in a vehicle.

Identifying and Reducing Choking Risks

The CMRC reissued a revised Health and Safety Alert entitled Choking Prevention and Intervention Update. CMRC noted risk factors related to individuals inadvertently obtaining access to food as a result of food-seeking behaviors and staff being unaware of the appropriate monitoring and supervision in the individual's plan. Risk factors that providers should be aware of include:

- Four out of five times the source of food that caused the choking incident was due to an individual taking food. For the cases in the review, none of the causes were due to food given inconsistent with diet.
- In almost all the cases, the risk for choking was inadequately identified by staff.

Choking continues to be one of the primary areas of focus and OPWDD seeks to further build on the tenets of its Choking Prevention Initiative. The CMRC would like, in collaboration with provider agencies and their staff, to:

- Increase awareness of the life-threatening risks of certain dining behaviors
- Ensure when pacing and supervision are identified as supports, the plans and assessments validate staff's essential role.
- Increase fluency with making effective and thoughtful decisions regarding safeguards that impact rights

Death Reporting and Investigations

OPWDD has developed and implemented statewide trainings to further improve services and supports, and enhance the quality and timeliness of death reporting and investigations. Provider agencies are advised to participate in these trainings, which are offered on an ongoing basis.

Case Review Findings

When warranted, the Central and Local Mortality Review Committees issue recommendations to provider agencies, to which agencies must respond. Agencies must include documented corrective or other actions that have or will be taken to address the committees' concerns. The CMRC has found that half of the recommendations issued relate to policies, procedures or protocols and skill, knowledge or training of staff. OPWDD has enhanced guidance to the field and training efforts to provide resources.

Provider Assessment Responsibilities

Policy, Procedures, Protocols

- Are available and accessible to staff in clearly written language
- Are up-to-date and communicated to staff on a regular basis
- Are a key part of training initiatives
- Are consistent with regulatory requirements and expectations
- Providers should be able to self-assess the need for improvements/changes to process, policies and procedures based on their own incident and mortality review

Skill, Knowledge or Training

- Staff have received adequate training, which is documented
- Staff are evaluated/observed to ensure they can implement what was learned during training
- Refreshers are offered, at least annually
- Training curriculums are continually reviewed and updated based on needs or identified gaps
- Staff are knowledgeable about the individuals in their care and are familiar with behavior plans and any special needs

Resources

Mortality Awareness and Prevention – Using Health and Safety Alerts

OPWDD issues Health and Safety Alerts, which are also sent to provider agencies via Executive Directors. These alerts are useful tools for agencies to engage in quality improvement and are available through OPWDD's website at www.opwdd.ny.gov.

By focusing on agency policies and procedures, staff training and mindfulness, and routine effective practices, provider agencies can improve the well-being of the individuals we serve and ensure appropriate safeguards are in place.

For more information about OPWDD's mortality process, please consult the website resources.