

 <p>ARIZONA DEPARTMENT OF CORRECTIONS</p> <p>DEPARTMENT ORDER MANUAL</p>	<p>CHAPTER: 1100</p> <p>INMATE HEALTH SERVICES</p>	<p>OPR:</p> <p>PS</p>
	<p>DEPARTMENT ORDER: 1105</p> <p><i>INMATE MORTALITY/ MORBIDITY REVIEW</i></p>	<p>SUPERSEDES:</p> <p>N/A</p>
		<p>EFFECTIVE DATE:</p> <p>JANUARY 18, 2005</p>

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PURPOSE

This Department Order establishes a quality assurance process pursuant to A.R.S. 36-2401, to review and evaluate the health and mental health care provided to inmates who are in the custody of the Department. The Department has developed this instruction to reduce the morbidity and mortality in the delivery of health and mental health care within the Department.

APPLICABILITY

This Department Order is applicable to all offender deaths and serious injuries that occur while the offender is in the care and custody of the Department.

PROCEDURES

1105.01 SERIOUS INJURY OF INMATE

- 1.1 All records, reports, databases, and meetings are protected by patient confidentiality and are to be held in strict confidence. All review reports shall be stamped "DO NOT COPY - QUALITY ASSURANCE REVIEW" and shall not be subject to disclosure.
- 1.2 Within 48 hours of receiving information of an serious injury, the institution Facility Health Administrator (FHA) shall review the information and forward it to the appropriate institution key contact staff member such as the supervising Physician, Nurse and Pharmacist, or Mental Health Key Contact, who shall:
 - 1.2.1 Review the information and determine whether the incident requires further review by Clinical or Administrative staff.
 - 1.2.2 Initially, determine whether medical/mental health staff handled the incident appropriately and forward to the FHA to ensure that a further comprehensive review occurs.
 - 1.2.3 Prepare an information assessment report to be returned to the FHA or to the Mental Health Program Manager (MHPM), which includes a case summary, stating why further review is or is not necessary, and making recommendations for appropriate or corrective action, if applicable.
- 1.3 Within 48 hours of receiving the information assessment the FHA shall review the information and forward a summary of the information to the appropriate Regional Health Administrator (RHA), and:
 - 1.3.1 Refer the incident to the institution's Warden for review of any security issues, if any.
 - 1.3.2 If appropriate, forward the information to the appropriate Review Committee to conduct an in-depth review of the issue/incident, if not otherwise reviewed.
- 1.4 The RHA or MHPM shall provide a summary report to the Health Services Administrator and the Quality Assurance Committee and:
 - 1.4.1 Review the summary of information and the inmate file.
 - 1.4.2 Determine whether any error was made by the Health Care/Mental Health staff.

- 1.4.3 Determine whether the information and analysis requires further review, and if so, ensure that the review does occur.

1105.02 ATTEMPTED SUICIDE BY INMATE

- 1.1 Within 48 hours of receiving information of an attempted suicide, the Mental Health Key Contact shall:
 - 1.1.1 Review the information and determine if the incident requires further review by Clinical or Administrative staff.
 - 1.1.2 Determine whether medical/mental health staff handled the incident appropriately and whether further review is required.
 - 1.1.3 Gather and or prepare information to be returned to the MHPM, which includes a case summary, for a determination whether further review is necessary, and make any recommendations for appropriate or corrective action, if applicable.
- 1.2 Within 48 hours of receiving the information the MHPM shall conduct a review and provide a summary of the information to the Counseling and Treatment Services Administrator, forward the information to the appropriate Review Committee to conduct an in-depth review of the issue/incident, if not otherwise reviewed, and:
 - 1.2.1 Refer information relating to medical issues to the Health Services Administrator for review and action, if any.
 - 1.2.2 Refer information relating to security issues to the institutional Warden for review and action, if any.
- 1.3 The Counseling and Treatment Services Administrator shall:
 - 1.3.1 Determine whether further review or action is required.
 - 1.3.2 Determine whether any error was made by the Health Care/Mental Health staff.
 - 1.3.3 Provide a summary report to the Quality Assurance Committee.

1105.03 MORTALITY REVIEW/INMATE DEATH - Upon the death of an inmate the following procedures shall be followed.

- 1.1 Institution Review - Within 72 hours of an offender death, the Facility Health Administrator of the affected institution, shall convene the Initial Mortality Review Committee (IMRC).
 - 1.1.1 The IMRC shall:
 - 1.1.1.1 Complete the Mortality Review – Case Abstract and Cover Sheet, Form 1105-1.
 - 1.1.1.2 Forward the completed form with copies of all pertinent medical progress notes (SOAP notes), Emergency Medical Services (EMS) notes and IMS Information Reports, prior grievances, medical request forms, and the inmate letters to the Medical Program Manager.
 - 1.1.1.3 Include the following issues for review:

- 1.1.1.3.1 Suicides.
 - 1.1.1.3.2 Delayed diagnosis.
 - 1.1.1.3.3 Incorrect diagnosis.
 - 1.1.1.3.4 Delayed treatment causing or contributing to serious injury or death.
 - 1.1.1.3.5 Avoidable deaths.
 - 1.1.1.3.6 Deviations from "community standards" for health care.
- 1.1.2 If the incident resulted in an IMS being initiated, the IMRC shall:
- 1.1.2.1 Include the affected Warden, Deputy Warden and unit Chief of Security in the initial meeting.
 - 1.1.2.2 Complete the Health Services IMS Critique Form, 1105-2, which shall be included in the file with the Mortality Review – Case Abstract and Cover Sheet form.
 - 1.1.2.3 Forward the complete file to the Medical Program Manager or to the MHPM in the case of suicide, who shall prepare a preliminary report of findings. This report shall be forwarded to the Counseling Treatment Services Administrator, Health Services Administrator, and Division Director for Program Services.
- 1.1.3 Upon receipt of the Autopsy and Toxicology reports from the County Medical Examiner's office, the FHA shall convene, within 72 hours, a Comprehensive Mortality Review Committee (CMRC). The CMRC shall:
- 1.1.3.1 Review the Autopsy and Toxicology reports and complete a secondary Mortality Review – Case Abstract and Cover Sheet, updating the facts and conclusions as appropriate.
 - 1.1.3.2 Forward the complete file and inmate's medical record to the Medical Program Manager to initiate the Central Office Review process or to the Counseling and Treatment Services Administrator, in the case of suicide, to initiate a Suicide Review Committee.
- 1.2 Central Office Review – Upon receipt of the complete file and the inmate's medical record the Medical Program Manager shall, in all instances, convene a Central Office Mortality Review Committee (COMRC) meeting.
- 1.2.1 Issues for review may include those outlined in 1.1.1.3.1 through 1.1.1.3.6 of this section and the Autopsy and Toxicology reports.
 - 1.2.2 The COMRC shall:
 - 1.2.2.1 Review the appropriateness of health care provided.
 - 1.2.2.2 Make recommendations concerning staff or discipline and policy or procedure changes, if any.
 - 1.2.2.3 Review the autopsy and toxicology report.

- 1.2.3 The Medical Program Manager shall consolidate the information in 1.2.2.1 through 1.2.2.3 of this section and publish the final report.
 - 1.2.4 The Medical Program Manager shall review the report with the Division Director for Program Services, the Regional Health Administrator and the Health Services Administrator, and recommend any corrective action plans, as required, utilizing the Central Office Mortality Review Committee Final Report, Form 1105-3. The report shall be forwarded to the Director through the chain of command. A copy shall be forwarded to the Quality Assurance Committee.
- 1.3 Suicide Review Committee - Upon receipt of the complete file and the inmate's medical record the Counseling and Treatment Services Administrator shall, in all instances, convene a Suicide Review Committee (SRC), as outlined in Department Order #1103, Inmate Mental Health Care, Treatment and Programs.
- 1.3.1 The SRC shall:
 - 1.3.1.1 Review Medical/Mental Health record, including autopsy and toxicology reports.
 - 1.3.1.2 Review any reports, Information Reports, investigation reports, and any Department documents relevant to the incident.
 - 1.3.1.3 Make recommendations concerning disciplinary actions, policy or procedural changes, as necessary.
 - 1.3.2 The MHPM shall consolidate the above information, enter it into the suicide database and publish a final report to the Counseling and Treatment Services Administrator.
 - 1.3.3 The Counseling and Treatment Services Administrator shall review the report packet with the Division Director for Program Services and the Health Services Administrator, and recommend any corrective action plans, as required. The report shall be forwarded to the Quality Assurance Committee.

1105.04 INMATE DEATH ADMINISTRATIVE INVESTIGATION - All incidents of inmate death, regardless of circumstances or cause, shall be referred for investigation as outlined in Department Order #601, Administrative Investigations and Employee Discipline.

DEFINITIONS

ADMINISTRATIVE REVIEW COMMITTEE - A committee convened quarterly to review policy and procedure recommendations forwarded from the Medical Peer Review Committee.

ATTEMPTED SUICIDE - An intentional and voluntary act of attempting to take one's own life, which results in hospitalization or significant or life threatening injury.

CENTRAL OFFICE MORALITY REVIEW COMMITTEE - Mortality review held in the Central Office Health Services Program Phoenix office with the following Committee members: Medical Program Manager, Nursing Program Manager, Pharmacy Program Manager and a Mental Health Program Manager.

COMPLEX MORTALITY REVIEW COMMITTEE - Mortality Review shall be held at the deceased offender's institution. The Committee consists of the following members: Facility Health Administrator, Key Contact Physician, Correctional Registered Nurse Supervisor II, Key Contact Pharmacist, Mental Health Key Contact, and as appropriate, the institutional Warden and Deputy Warden of the offender's unit.

MENTAL HEALTH KEY CONTACT - The Psychologist III at each facility who oversees the mental health program for that facility.

SERIOUS INJURY - A medical condition involving an inmate that, if not treated immediately, would result in serious medical complications, loss of life, or permanent impairment to bodily functions, e.g., uncontrolled bleeding, loss of consciousness, poisoning, severe shortness of breath, severe chest pain, paralysis, suspected overdose of medication, and apparent stroke.

UNEXPECTED DEATH - Death in which the cause of death is not immediately known or anticipated.

{Original Signature on File}

Dora B. Schriro
Director

FORMS

- 1105-1, Mortality Review - Case Abstract and Cover Sheet
- 1105-2, Health Services - IMS Critique
- 1105-3, Central Office Mortality Review Committee Final Report

AUTHORITY

- A.R.S. 36-441, Health Care Utilization Committees; Immunity; Exception; Definition
- A.R.S. 36-445, Review of Certain Medical Practices
- A.R.S. 36-2401, Definitions
- A.R.S. 36-2403, Confidentiality; protection from discovery proceedings and subpoena; exceptions
- A.R.S. 36-2404, Quality Assurance Review Committees