Unexpected Fatality Review

DOC Corrective Action Plan

2021 Unexpected Fatality UFR-21-001

Report to the Legislature

As required by Engrossed Substitute Senate Bill 5119 (2021)

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Legislative Directive

Engrossed Substitute Senate Bill 5119 (2021)

Unexpected Fatality Review Governance

RCW 72.09.770 requires the Department of Corrections (DOC) to convene an Unexpected Fatality Review (UFR) committee and meeting in any case "in which the death of an incarcerated individual is unexpected, or any case identified by the office of the corrections ombuds." The department is also required to issue a report on the results of the review within 120 days of the fatality and, within 10 days of completion of the review, develop an associated corrective action plan to implement any recommendations made by the review team. The statute took effect July 25, 2021.

The "primary purpose of the unexpected fatality review shall be the development of recommendations to the department and legislature regarding changes in practices or policies to prevent fatalities and strengthen safety and health protections for prisoners in the custody of the department."

"'Unexpected fatality review' means a review of any death that was not the result of a diagnosed or documented terminal illness or other debilitating or deteriorating illness or condition where the death was anticipated and includes the death of any person under the jurisdiction of the department, regardless of where the death actually occurred. A review must include an analysis of the root cause or causes of the unexpected fatality, and an associated corrective action plan for the department to address identified root causes and recommendations made by the unexpected fatality review team under this section."

Unexpected Fatality Review Committee Report

The department issued the UFR committee report on December 14, 2021 (DOC publication 600-SR001). This document includes the required corrective action plan. The department is required to implement the corrective actions within 120 days of the publication of the committee report.

Corrective Action Plan

UFR Committee Recommendations	DOC Corrective Actions	Expected Impacts
Evaluate ways to follow higher-risk patients more closely as part of a chronic care management program.	1) Prioritize recruitment for 10 chronic care management nurses (a newly created position) to develop and implement a chronic care management program. 2) Develop prioritization matrix for potential categories of chronic care patients.	*Improved health outcomes for high-risk patients.* Chronic care management programs require dedicated care management nurses and appropriate identification of patients who may benefit from care management.
Address decision-making considerations regarding medical site of care for patient evaluation and monitoring depending on facility capacity and resources.	1) Deputy Chief Medical Officer will provide direction to the Facility Medical Directors (FMD) group on clinical practice decisions for infirmary admission vs. emergency room referral.	*Improved patient safety.* Improved understanding of considerations for care escalation are likely to result in the safest and most clinically appropriate patient placements.
Educate staff on medical practitioner on-call protocol and expectations ("on-call escalation") that were updated in 2020.	1) Establish practice of regularly updating and post the on-call schedule in the infirmary and outpatient triage rooms. 2) Post the on-call protocol in the infirmary and outpatient triage rooms. 3) Include reminders in the nursing newsletter of the on-call protocol.	*Nurses and/or staff members at patient bedsides have access to on-call clinicians when needed.* The on-call protocol explains whom to call if the first-line provider is not immediately reached. Regularly updating the on-call schedule ensures that phone numbers are correct and accessible.

Reduce barriers to prompt emergency room referrals.	1) Update offender health plan to clarify direction that any DOC provider can call 911 when deemed necessary. 2) Train appropriate staff on updated changes	*Reduce barriers to ambulance response for patients experiencing life-threatening crises.* Eliminating confusion about the need for pre-authorization regarding calls to 9-1-1 can help ensure patient safety by preventing unnecessary delays.
Improve reliability of primary care provider notification and follow-up after medical emergency.	1) Identify countermeasures in the process for completing provider notification of and follow-up after medical emergency. Countermeasures will be pursued outside of this corrective plan.	*Patients have reliable access to follow-up care when needed.* Nurses who perform face-to-face triage of patient need process tools to plan appropriate follow-up.
Consider ways to better educate and engage patients in medication compliance and self-care.	1) Include medication reconciliation on the checklist of activities Medical Assistants complete for routine appointments.	*Patients have the opportunity to discuss with providers reasons they might not be taking prescribed medications, and providers have the opportunity to better educate patients on medication use.*
Promote standardized clinical communication tools for patient care handoff.	1) Start an SBAR (situation, background, assessment, recommendation) communication pilot.	*Improve reliability of care handoffs.* The SBAR provides an evidence-based structure to promote better communications and enhance continuity of patient care.
Improve medical record documentation quality including ensuring legibility of handwriting.	1) The quality team will initiate a process improvement project to identify and resolve barriers to legible documentation. 2) Health Service Administrators and Clinical staff will provide training to staff on the expectations of changes.	*Improved patient care and safety through better documentation.*