Vermont Psychiatric Care Hospital Procedure	
Patient Death	
Revised: X	Date: 2/22/18

PURPOSE:

- To ensure that the patient's wishes are respected in the event of death.
- To ensure compliance with applicable state and federal requirements.
- To ensure timely transfer of patient information to expedite removal and disposition of the expired patient.
- To encourage timely evaluation of facility procedures and staff actions.

PLEASE NOTE:
In all instances, but especially when a patient's death is anticipated, every effort shall be made to comply with the patient's documented wishes.

- A copy of the Advance Directive and the Do Not Resuscitate (DNR)/Do Not Intubate (DNI) order, if available, shall be included in the patient's medical record
- The presence of the Advance Directive and the DNR/DNI order shall be prominently noted on the binder of the patient's medical record.
- A signed physician order is not required to comply with a patient's Advance Directive.

(See Advance Directives Policy and Procedure for specific guidance)

CONSIDERATIONS/REQUIRED STEPS:

The following procedures address those actions to be taken after a patient's death has been pronounced by a physician.

I. General Guidelines for all Staff:

A. Pronouncing death: Only a physician may pronounce death. The physician pronouncing death shall document death in the deceased patient's medical record and shall inform the VPCH Medical Director or designee.

B. The body must not be moved: The State's Attorney shall be in charge of the patient's body. The patient's body shall not be moved or otherwise disturbed without the State's Attorney's instruction to do so. If authorized by the State's Attorney, the body may be moved under the direction of the nursing supervisor to a secure room to serve as a temporary holding area until transport is available.

II. Physician Responsibilities

A. Pronouncing death: Only a physician may pronounce death. The physician pronouncing death shall document death in the deceased patient's medical record and shall notify the Medical Director or designee. The physician shall also complete part 1 of the VPCH Mortuary Report (RC 11-07), the Medical Examiner completes part 2.

This and other required forms are kept in Admissions and will be brought to the deceased patient's location by nursing staff.

B. **Admissions to assist with notifications:** After pronouncing death, the physician shall instruct (or will request that a registered nurse instruct) the Admissions Specialist to initiate a sequence of calls (see Admission Specialist Procedures, section IV).

C. **MD speaks with the State Medical Examiner:** The VPCH physician pronouncing patient death shall, during the course of post-mortem events, speak directly with the Medical Examiner or Assistant Medical Examiner regarding the patient's death (Admissions will call the Medical Examiner for initial notification).

D. **Notify family and others:** The physician or nurse shall attempt to notify the patient's family, guardian, significant other, or other designated personal representative. If the person(s) to be notified cannot be reached by telephone, the physician or nurse shall ensure that the local police in that person's community are contacted for assistance with home notification. Admissions staff may be asked to assist with notification of local police.

E. **MD may be asked to speak with New England Organ Bank:** Following all patient deaths at VPCH, Admissions shall notify the New England Organ Bank (NEOB) (see Admission Specialist Responsibilities, section IV). The NEOB may request to speak with the physician.

III. Nursing Responsibilities

A. **Secure the scene:** The Nursing Supervisor or designee shall secure the scene of the patient's death until instructed otherwise by the State's Attorney (*See VPCH Securing the Scene of an Event Procedure*).

B. **The body must not be moved:** The State's Attorney shall be in charge of the patient's body. The patient's body shall not be moved or otherwise disturbed without the State's Attorney's instruction to do so. If authorized by the State's Attorney, the body may be moved under the direction of the nursing supervisor to a secure room to serve as a temporary holding area until transport is available.

C. **Attend to other patients:** Members of the nursing staff should direct patients away from the area where the body is located. If possible, the area should be locked.

D. **Acquire form and Postmortem Pack from Admissions:** The VPCH Mortuary Report form and a Postmortem Pack are kept in Admissions and shall be brought to the deceased patient's location by a member of the nursing staff.
   - **Mortuary Report** (RC 11-07): Completed by VPCH MD and Medical Examiner.
   - **Postmortem Packs containing identification tags:** Postmortem Packs are obtained from a funeral director and contain materials to be used by the funeral director when preparing the body for transport out of the hospital. The Postmortem Packs contain three identification tags that are to be completed by

either a VPCH physician or nurse, and attached to the patient's toe, personal effects, and to the outside of the plastic shroud that will be placed on the patient's body by the funeral director.

E. Informing other patients: The Nursing Supervisor or designee and the physician, in consultation with the Medical Director, shall determine collaboratively whether or not to inform other patients on the unit of the patient's death. When it is decided to inform other patients of the patient's death, consideration shall be given to how and when it would be best to communicate this information.

***F.* Complete a Patient Event Report:** The Nursing Supervisor or designee shall ensure that a Patient Event Report is completed as outlined in the *VPCH Event Reporting Procedure.*

IV. Admissions Specialist Responsibilities

A. Admissions to assist with notifications: The physician shall instruct (or will request that a registered nurse instruct) the Admissions Specialist to call the following individuals to inform them of a VPCH patient's death.
Please make the calls in this order and document the name/date/time of each person notified, and which VPCH staff member made each call:

1. Vermont State Police - Middlesex (229-9191)
Admissions shall ask the State Police if they will call the Medical Examiner or if Admissions should make this call.
2. State Medical Examiner's 24-hour telephone line for reportable deaths (1-888-552-2952). The Assistant Medical Examiner who receives this call will then notify the State's Attorney. The VPCH Chief Executive Officer has delegated to the Admissions staff the authority to call the Medical Examiner's office to report a patient death.
3. New England Organ Bank (NEOB) (24-hour telephone number: 1-800-446-6362) and be prepared to provide the information outlined in the *GMPCC Organ and Tissue Donation Policy and Procedure.* PLEASE NOTE: This call must be made within 1 hour of the time of the patient's death.
4. VPCH Chief Executive Officer or designee
5. Commissioner of the Department of Mental Health or DMH Administrator on call.
6. The patient's VPCH attending physician
7. Perkins-Parker Funeral Home (telephone: 244-7223)
8. Call Quality (828-2962 and 828-3197). If no anwer, leave the information on voicemail.

B. If requested by a physician or nurse, notify local police: If the physician or nurse is unable to notify the patient's family, guardian, significant other, or other designated personal representative by telephone, Admissions staff may be asked to call the local police for assistance with home notification.

C. **Organize forms and other materials for clinical staff:** The following form and Postmortem Pack are stored in the Admissions Ovvice and shall be organized and provided to a member of the nursing staff for use at the scene of the patient's death.

1. **Mortuary Report** (RC 11-07)
2. **Postmortem Packs containing identification tags** (kept in Patient Valuables drawer marked VPCH)

V. Transport of the body / Relating with the funeral director

A. **Transport of the body from VPCH:** Transport of the body will occur only after clearance from the State's Attorney. The funeral director will transport the body to either the Medical Examiner or to the funeral home as directed by the State's Attorney.

B. **Local funeral home:** Perkins-Parker Funeral Home in Waterbury will be available to receive the body of a deceased patient when there are no burial funds. The State will be responsible for the expenses.

C. **Other preferred funeral home:** If the patient or legally authorized representative had specified a preferred funeral home, this preference shall be honored. If the funeral home is located outside Vermont, the State shall not be responsible for transport expenses.

D. **Information for funeral director:** The funeral director shall be provided telephone numbers of the deceased patient's family, guardian, significant other, or other designated personal representative, for purposes of making funeral and burial arrangements.

VI. Additional Information for All Staff

A. **Investigation:** By law, all deaths at the Vermont Psychiatric Care Hospital (VPCH), whether anticipated or unanticipated, require investigation by the Office of the Chief Medical Examiner and the Vermont State Police (VSP). The Medical Examiner, working with the State's Attorney and VSP, will determine the degree of investigation required.

B. **Postmortem care:** Postmortem care is not performed at VPCH.

C. **Autopsy considerations:** Either the State's Attorney or Medical Examiner may order an autopsy. In instances where an autopsy is ordered, it will be performed by the Medical Examiner.

VII. Quality Department Responsibilities

A. Notification of Patient Safety and Surveillance Improvement System. Any patient death must be reported to the Patient Safety and Surveillance Improvement System at:

Vermont Program for Quality in Healthcare
132 Main Street
Montpelier, Vermont 05602
1- 802-229-2152

B. Notification of CMS

If the patient's death was directly or indirectly related to an emergency involuntary procedure it must be reported to the Centers for Medicare and Medicaid Services (CMS Regional Office) pursuant to the *VPCH Event Review Policy and Procedure.* Notification of CMS must occur not later than the close of the next business day following knowledge of the patient's death.

"Death directly or indirectly related to an emergency involuntary procedure" is defined as follows:

- Each death that occurred while the patient was in restraints (whether physical or drugs used as a restraint), or seclusion,
- Each death that occurred within 24 hours after the patient had been removed from restraint or seclusion; and
- Each death that occurred within 1-week after restraint or seclusion where it is reasonable to assume that the use of restraint or seclusion contributed directly or indirectly to a patient's death. "Reasonable to assume" in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction or breathing or asphyxiation.

In the event that a death related to an emergency involuntary procedure is reported to CMS, staff must document in the patient's medical record the date and time the report was made.

C. Administrative and Clinical Quality Review

Following any unanticipated patient death, a Root Cause Analysis shall be completed by the Quality Department and reported to the Commissioner of the Department of Mental Health, the VPCH Chief Executive Officer or designee, to the Medical Director or designee, to other members of the Vermont Psychiatric Care Hospital Leadership Team, and to the deceased patient's treatment team, unless otherwise directed by the VPCH Chief Executive Officer or designee.

Approved by	**Signature**	**Date**
Melissa Bailey **Commissioner of DMH**	Melissa Bailey	**Febraury 22, 2018**