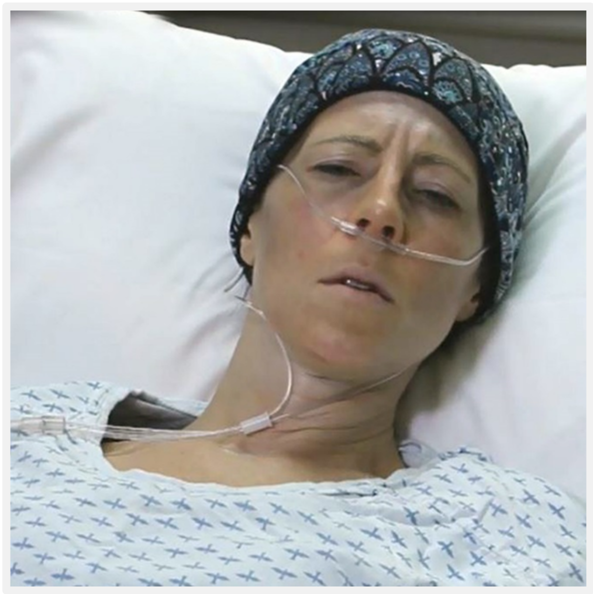
END OF LIFE CARE

Estimated Time: 30 minutes • Debriefing Time: 60 minutes



Scan to Begin

Patient Name: Laura C. Anderson

SCENARIO OVERVIEW

Laura is a 35-year-old female with end stage lung cancer who was transported to the ER two days ago via ambulance when her mother found her at home with decreased level of consciousness and respiratory difficulty. She was admitted to the med-surg unit for pain management, and hospice services were initiated after meeting with the palliative care nurse. Morphine oral solution was initiated and titrated to an effective dose for pain and air hunger. Today, the nurse's shift to shift report indicates that Laura is actively dying and the mother is not coping well. As the student walks into Laura's room with her mother at her bedside, the patient dies. The student must implement the facility's death management protocol including postmortem care, notification of the physician and funeral home, recognition of when the Medical Examiner's presence is required, and potential initiation of organ/tissue donation procedures.

LEARNING OBJECTIVES

(Based on AACN End-of-Life Nursing Education Consortium: Recommended Competencies and Curricular Guidelines for End-of-Life Nursing Care)

1. Communicate effectively and compassionately with the family, and health care team members about end-of-life issues
2. Recognize one's own attitudes, feelings, values, and expectations about death and the individual, cultural, and spiritual diversity existing in these beliefs and customs
3. Demonstrate respect for the patient's views and wishes during end-of-life care
4. Apply legal and ethical principles in end-of-life care, recognizing the influence of personal values, professional codes, and patient preferences
5. Incorporate spiritual health during end-of-life care
6. Explain the processes associated with organ donation

CURRICULUM MAPPING

WTCS NURSING PROGRAM OUTCOMES

- Implement one's role as a nurse in ways that reflect integrity, responsibility, ethical practices, and an evolving professional identity as a nurse committed to evidence-based practice, caring, advocacy and quality care
- Demonstrate appropriate written, verbal, and nonverbal communication in a variety of clinical contexts
- Integrate social, mathematical, and physical sciences, pharmacology, and pathophysiology in clinical decision making
- Provide patient centered care by utilizing the nursing process across diverse populations and health care settings
- Minimize risk of harm to patients, members of the healthcare team and self through safe individual performance and participation in system effectiveness
- Lead the multidisciplinary health care team to provide effective patient care throughout the lifespan
- Use information and technology to communicate, manage data, mitigate error, and support decision-making

NURSING FUNDAMENTALS

- Maintain a safe, effective care environment for adults of all ages.
- Use appropriate communication techniques
- Use the nursing process
- Provide nursing care for patients and families experiencing grief and loss
- Adapt nursing practice to meet the needs of diverse patients in a variety of settings

NURSING HEALTH PROMOTIONS

- Apply principles of family dynamics to nursing care
- Use principles of teaching/learning when reinforcing teaching plans

NURSING MANAGEMENT AND PROFESSIONAL CONCEPTS

- Apply principles of prioritization when evaluating nursing care in complex situations
- Apply principles of delegation and supervision when evaluating nursing care
- Collaborate with multidisciplinary team members to plan care
- Analyze ethical dilemmas in health care
- Analyze legal implications of nursing practice in healthcare

SIMULATION LEARNING ENVIRONMENT & SET-UP

ENVIRONMENT

Inside room: Patient on bed, hospital room setting, simulation shift start time of 0700

Inside or outside room: Hand sanitizer or sink

Outside room: Medications, printed copy of the “Client/Patient/Resident Death Determination” form located in Appendix B, printed copy of the “Notice of Removal of a Human Corpse from a Facility” form located in Appendix C

PATIENT PROFILE

Name: Laura C. Anderson

DOB: 04/16/19XX

Age: 35

MR#: 0912

Gender: Female

Height: 152.4 cm (65 inches)

Weight: 47.62 kg (105 lbs)

Code Status: DNR, comfort cares only

Spiritual Practice: Catholic

Ethnicity: Caucasian

Primary Language: English

Admitting Diagnosis: Chronic Pain, neoplasm related (G89.3)

Chronic Medical Diagnoses: Metastatic Lung Cancer (C34.0)

Allergies: NKDA

EQUIPMENT/SUPPLIES/SETTINGS

Patient

- Wearing hospital gown
- Moulage to appear gray blue, thin and emaciated
- Bandana/turban on head (no hair)
- ID band present with QR code
- Bible and rosary by bed
- Nasal cannula in place and set O2 at 3L/min

Monitor Settings

- No monitor
- Simulator Vitals: no vitals as patient has just died

Family Member

- Mom is present during this scenario. Options:
    - Mom played by the technician
    - Mom played by actor
    - Mom role-played by a student
    - Mannequin or picture sitting in chair with “Mom” QR code attached
    - Mom “just left the room” after students watch the video of the mother’s concerns.

Supplies

- General
    - Equipment to obtain vitals including oxygen saturation
    - Phone
- Medications available (realistic labels are available by scanning the QR code)
    - Morphine oral solution (100 mg/5ml)
    - Lorazepam liquid

QR CODES

TEACHING PLAN

PREBRIEF

The facilitator should lead this portion of the simulation. The following steps will guide you through Prebrief.

- Scan the "Scan to Begin" QR Code while students are in Prebrief
- "Meet Your Patient" and "Meet the Family" (on iPad) and explain how the iPad works in the simulated learning environment including:
    - Explain how to use the iPad scanner and QR codes. Remind students that there are multiple QR codes in the simulation, but they should only scan them if they think it will provide data necessary for their assessment and evaluation of the patient.
    - For some scenarios, it may be helpful to tell students where the QR Code are located. For others, you may want students to "find" the QR Codes during their assessments. This is your choice.
    - As the facilitator, you should be aware that throughout the simulation some QR codes are necessary to the programming of the iPad content. Directions for which QR codes are required (to be scanned) in each state are listed under each state of the documentation below. The QR codes are also in **BOLD** type.
    - MAR Hyperlinks – On the MAR all medications are underlined and hyperlinked to DailyMed, which is a medication reference housed by the National Library of Medicine. Students can click on these links during the simulation for up-to-date medication content, labels, and package insert information.
    - Level Up tab – This tab "tells" the content in the iPad to change to what is needed for the next state of a simulation. It also helps student know where they are at in a scenario and it may give "clues" as to how to progress.
- Discuss the simulation "Learning Objective(s)" (on iPad) as well as any other Prebrief materials
- Play the "Report" video (on iPad)
    - Possible Facilitator Question
        - What are your priorities after listening to report?

- Play the “Patient” video (on iPad)
    - Possible Facilitator Questions
        - What are your assessments at this time?
        - What do you need to do at this moment?
- Play the “Mom” video (on iPad)
    - Possible Facilitator Questions
        - How will you communicate therapeutically and compassionately at this moment?
        - Facilitator Note: The facilitator or technician may elect to role play the mom at this time and allow the student to role play therapeutic communication before proceeding with the scenario.
- Advance to the “Patient Profile” screen (on iPad). This will act as a simulated patient chart.
- Students may view the tabbed content on the iPad (see below) prior to entering the patient’s room and throughout the simulation as needed.
- After students view the available tabbed iPad content (below), they need to scan **QR Code: Facilitator** PRIOR to entering the patient’s room.
    - This scan is a programmed feature in the iPad that automatically populates two additional iPad tabs (students are not prompted to this).
    - Those new tabs are:
        - Patient Death Determination Form
        - Removal of a Human Corpse

H&P

Name: Laura C. Anderson

MR#: 0912
DOB: 04/16/19XX

Date: On admission

CHIEF COMPLAINT/HISTORY OF PRESENT ILLNESS: This is a 35-year-old female brought to the ER with decrease in level of consciousness and respiratory difficulty. She has end stage lung cancer. Biopsy of right lower lobe 9 months ago revealed carcinoma that has now metastasized to the bone and brain. The patient has received eight monthly cycles of chemotherapy but requested hospice services one week ago according to her oncologist, Dr. Benton. She is accompanied by her mother who states she wants "everything possible done for her daughter." No advance directives are in place.

PAST MEDICAL HISTORY: Lung Cancer with metastasis to brain and bone

MEDICATIONS:

- Fentanyl patch 25 mcg every 72 hours for pain
- Oxycodone ER 80 mg PO every 12 hours PRN for pain
- Docusate sodium 100 mg PO BID for constipation
- Compazine 10mg PO every 4-6 hours for nausea PRN

ALLERGIES: NNDA

SOCIAL HISTORY: Single; No children; Lives alone. No advanced directives.

REVIEW OF SYSTEMS: Abbreviated due to end of life condition.

HEENT: Mother reports change in level of consciousness. Denies headaches or change in vision.

Respiratory: Complains of productive cough of white, blood streaked sputum and worsening shortness of breath. Complains of chest pain worse on inspiration.

Cardiovascular: Denies palpitations.

Peripheral Vascular: Denies claudication, leg cramps, paresthesias or edema.

Gastrointestinal: Mother reports "no appetite" and "has been losing a lot of weight." Patient complains of nausea and vomiting relieved with Compazine. Patient complains of constipation that she treats with docusate sodium.

Genitourinal: Patient reports dark, concentrated urine but no dysuria or hematuria.

PHYSICAL EXAM:

General Appearance: 35-year-old female who appears emaciated and withdrawn. Alert but drowsy. Avoided eye contact and stated, "just let me die."

Vital signs from paramedics: BP= 154/74 T= 38.1 C HR= 130 RR= 25 O2= 85% on RA

Height= 162.5 cm (65 inches) Weight= 47.62 kg (105 lbs)

HEENT: unremarkable, PERRLA

Neurological: Eyes open to speech, oriented x3. Visibly fatigued. Flat affect. GCS 14.

Cardiovascular: Normal heart sounds. No murmurs.

Respiratory: Course crackles throughout with occasional wheeze.

Abdomen: Hypoactive, non-distended.

Vascular/Extremities: Strength 2/5. Sensation and reflexes intact. Skin dry.

Rectal: Deferred.

LABORATORY AND DIAGNOSTIC STUDIES: ABGs STAT, CBC, Chem 7

ASSESSMENT/PLAN: End stage cancer; end of life.

- Admit to medical floor for pain management.
- Initiate home medications.
- Hydromorphone IV 0.5mg STAT and every 2 hours PRN for severe pain.
- Dexamethasone 20 mg PO.
- Bedrest.
- Diet as tolerated.
- Oxygen therapy to maintain O2 sat >90%.
- Consult for respiratory therapy.
- Palliative care consult.

I discussed with patient and mother her current end-stage lung cancer status and recommended hospice care, initiation of advance directives and DNR status. No decision was made so will order follow-up with palliative care consult.

Electronically signed – Dr. Bennett, M.D.

ORDERS

Orders

Patient Name: Laura C. Anderson
DOB:04/16/19XX Weight(kg):47.62
MR#: 0912
Provider: Dr. Bennett
Allergies: NKDA

Date	Time	Order
Two days ago	2100	Admit to medical floor
		Bedrest
		Diet as tolerated
		Respiratory therapy consult
		Maintain O2 sat > 90%, start O2 via NC at 2 L and titrate prn
		ABGs STAT
		Palliative Care Consult
		Hydromorphone 0.5mg IV every 2 hours PRN for severe pain
		Fentanyl patch 25 mcg every 72 hours for pain
		Oxycodone ER 80 mg PO every 12 hours PRN for pain
		Docusate sodium 100 mg PO BID for constipation
		Compazine 10mg PO every 4-6 hours for nausea PRN
		Dexamethasone 4 mg PO daily
		Obtain advanced directives
		CBC, Chem 7
		---------------------------Dr. Bennett, M.D.
Yesterday	0900	Morphine100mg/5ml oral solution 20 mg (1 ml) STAT and q 1 hour PRN for severe pain
		Ondansetron 8 mg dissolving tab every eight hours PRN for nausea
		Discontinue Oxycodone ER 80 mg after first dose of Morphine

NURSING | LEVEL: 4

		Discontinue Compazine 10 mg
		Discontinue Fentanyl patch after first dose of Morphine
		Start hospice services
		Code Status: DNR with advance directives in place
		Discontinue lab work orders
		Polyethylene glycol 17 grams daily PRN for constipation
		Senna 8.6 mg PO 2 tabs daily
		Dulcolax 10 mg suppository prn for constipation
		Lorazepam sublingual 2mg/ml every 4 hours prn for terminal agitation
		---------------------------- Nancy Hospes, RN, APN-BC, Palliative Care Specialist/Dr. Hospita
Yesterday	1300	Morphine100mg/5ml oral solution 30 mg (1.5 ml) q 1 hour PRN for severe pain or air hunger
		------------------ Nancy Hospes, RN, APN-BC, Palliative Care Specialist/Dr. Hospita
Yesterday	1800	Morphine100mg/5ml oral solution 40 mg (2 ml) q 1 hour PRN for severe pain or air hunger
		------------------ Nancy Hospes, RN, APN-BC, Palliative Care Specialist/Dr. Hospita

Continue >

MAR

MAR

Patient Name: Laura C. Anderson
DOB:04/16/19XX Weight(kg):47.62
MR#: 0912
Provider: Dr. Bennett
Allergies: NKDA

Order	Sch. Time	Dose
Fentanyl patch 25 mcg every 72 hours for pain(Discontinued)	Two days ago 2100 Patch removed yesterday 0900	
Oxycodone ER 80 mg PO every 12 hours PRN for pain (Discontinued after first does of Morphine)	Yesterday 0300	
Docusate sodium 100 mg PO BID for constipation	Two days ago 2100	
Compazine 10mg PO every 4-6 hours for nausea PRN(Discontinued)		

Hydromorphone 0.5mg IV every 2 hours prn for severe pain	Two days ago 2100, 2300 Yesterday 0300	
Dexamethasone 4 mg PO daily	Two days ago 2100 Yesterday 2100	
Morphine 100mg/5ml oral solution 20 mg (1 ml) STAT and q 1 hour PRN for severe pain (Discontinued yesterday at 1300 - see new order)	Yesterday 0900 Yesterday 1000 Yesterday 1100 Yesterday 1200	
Ondansetron 8 mg dissolving tab every eight hours PRN for nausea	Yesterday 1100	
Polyethylene glycol 17 grams PO daily PRN for constipation	Yesterday 1100	
Senna 8.6 mg 2 tabs dailyPO	Yesterday 1100	

Dulcolax 10 mg suppository PRN daily for constipation		
Morphine 100mg/5ml oral solution 20 mg (1 ml) STAT and q 1 hour PRN for severe pain (Discontinued yesterday at 1800 - see new order)	Yesterday 1300 Yesterday 1500 Yesterday 1700	
Morphine 100mg/5ml oral solution 20 mg (1 ml) STAT and q 1 hour PRN for severe pain or air hunger	Yesterday 1800 2100 2300 Today 0330 0500 0600	
Lorazepam sublingual 2mg/ml every 4 hours PRN for terminal agitation		

Continue >

DAILY RECORD

Vitals – Yesterday 0900:

BP: 85/54

P: 55

RR: 6

O2: 85% on 3 L

T: 39°C

VITALS

The iPad shows the enterable vitals screen.

- Simulator vitals are set to 0

PAIN ASSESSMENT

Pain Assessment

Critical Care Pain Observation Tool

Indicator	Description	Score	
Facial expression	No muscular tension observed	Relaxed, neutral	0
	Presence of frowning, brow lowering, orbit tightening, and levator contraction	Tense	1
	All of the above facial movements plus eyelid tightly closed	Grimacing	2
Body movements	Does not move at all (does not necessarily mean absence of pain)	Absence of movements	0
	Slow, cautious movements, touching or rubbing the pain site, seeking attention through movements	Protection	1
	Pulling tube, attempting to sit up, moving limbs/ thrashing, not following commands, striking at staff, trying to climb out of bed	Restlessness	2
Muscle tension	No resistance to passive movements	Relaxed	0
Evaluation by passive flexion and	Resistance to passive movements	Tense, rigid	1
extension of upper extremities	Strong resistance to passive movements, inability to complete them	Very tense or rigid	2
Compliance with the ventilator (intubated patients)	Alarms not activated, easy ventilation	Tolerating ventilator or movement	0
	Alarms stop spontaneously	Coughing but tolerating	1
	Asynchrony: blocking ventilation, alarms frequently activated	Fighting ventilator	2
OR			
Vocalization (extubated patients)	Talking in normal tone or no sound	Talking in normal tone or no sound	0
	Sighing, moaning	Sighing, moaning	1
	Crying out, sobbing	Crying out, sobbing	2
Total, range			0-8

Original source: Gélinas C, Fillion L, KA, Viens C, Fortier M. Validation of the Critical-Care Pain Observation Tool in adult patients. *Am J Crit Care*. 2006;15(4):420-427. Table 1. Available at: http://ajcc.aacnjournals.org/content/15/4/420.short. ©2006 American Association of Critical-Care Nurses. Used with permission.

PROGRESS NOTES

Progress Notes

Patient Name: Laura C. Anderson
DOB:04/16/19XX MR#: 0912

Progress Notes

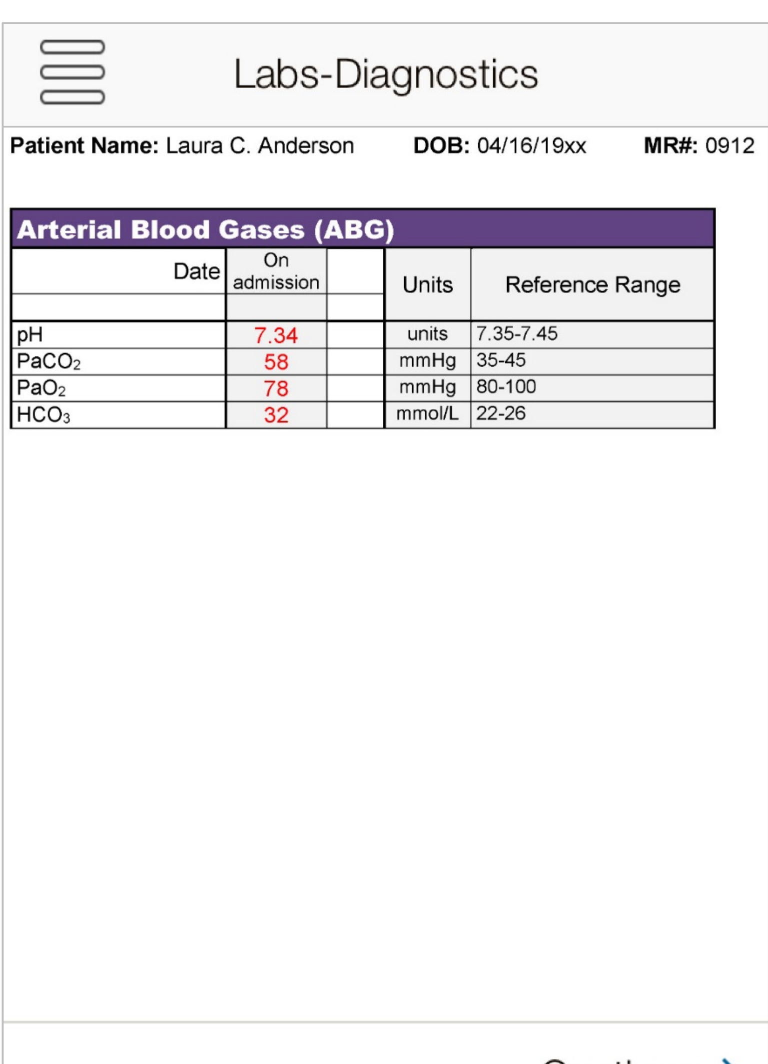
Date & Time	Note
Yesterday - 0630 Respiratory Therapy Consult	Patient was admitted with end stage lung cancer. Maintaining oxygen saturation at 89-90% on O2 at 2L/min via nasal cannula. ABGs were drawn this morning indicating respiratory acidosis. Patient refuses BiPAP despite extensive education about its benefits. States, "just let me die." Notified Dr. Bennett and requested DNR order per patient request. Palliative care nurse arrived during our visit. Continue oxygen via nasal cannula to maintain O2 sats >90%. ------------- ------------------ Randy Therp, RT
Yesterday - 0730 Palliative Care Consult	Patient presented to ER last night after mother called 911 due to worsening level of consciousness and respiratory status. Patient has metastatic lung cancer to brain and bone. Patient agreed to hospice services a week ago but mother has stated "wants everything possible done for her daughter." Patient complained of severe pain on arrival while taking Oxycodone 80 mg ER every 12 hours, Fentanyl patch 25 mg every 72 hours at home. Dilaudid 0.5 mg IV every 2 hours PRN was started on admission. Patient states pain improved after "a few doses, but woke up in severe pain" this morning. Patient states she has not tried Morphine in the past because of her "fear of addiction." Reviewed the "Honoring Choices" video and documentation with patient and her mother and thoroughly explained palliative care with focus on patient comfort. After discussion, patient agreed to DNR status and completed her advanced directive document. She elected to state her personal wishes as outlined in the document and not select a POA. The DNR document was signed by Dr. Hospita, and advanced directive signed by two witnesses. Both are on file in the electronic record. Patient desires no IVs, no bloodwork and no feeding tube. Is willing to try Morphine oral solution at this time with her goal to go home on Morphine solution. Discontinue Oxycodone ER, Fentanyl and Compazine and start Morphine oral solution 100mg/5ml 20mg (1 ml) every one hour PRN for pain. I will monitor her status closely and titrate dosage based on her response. Ondansetron 8mg

	dissolving tablets one tab every 8 hours added for nausea and Senna, polyethylene glycol powder and bisacodyl suppositories added for treatment of constipation as patient "cannot recall" when her last BM occurred. Mother states, "I think it was 3 days ago - before I left town." Mother encouraged to attend our hospice support group for caregivers and grief materials provided. --------------------Nancy Hospes, RN, APN-BC, Palliative Care Specialist/Dr. Hospita
Yesterday - 1300	Patient continues to complain of pain "greater than 10 out of 10" after several doses of Morphine 20 mg. Increase dose of Morphine to 30 mg (1.5 ml) every one hour PRN. --------------------Nancy Hospes, RN, APN-BC, Palliative Care Specialist/Dr. Hospita
Yesterday - 1800	Patient pain has improved on Morphine 30 mg but still requesting pain medication every two hours for pain "greater than 10 out of 10." Increase dose of Morphine to 40 mg (2 ml) every one hour PRN. Notify me if patient awakens in severe pain through the night. -------------------Nancy Hospes, RN, APN-BC, Palliative Care Specialist/Dr. Hospita
Nursing Notes	
Yesterday 0900	Patient rates pain "20 out of 10". New orders received from hospice NP. Fentanyl patch removed. Morphine 20 mg oral solution administered. ------------------------------ Susan Smith, RN
Yesterday 1000	Patient rates pain "15 out of 10" and "whole body hurts." Morphine 20 mg administered and repositioned. -Susan Smith, RN
Yesterday 1100	Patient reports pain as 12/10 after two doses of Morphine 20 mg oral solution. Morphine 20 mg administered as well as Senna and Polyethylene. Patient "cannot recall" date of last BM. Repositioned. ------------------------------ Susan Smith, RN
Yesterday 1200	Patient reports pain has improved but still 10/10. Will notify hospice services. Morphine 20 mg solution administered. ----------------------------- Susan Smith, RN
Yesterday 1300	New orders received from hospice NP. Morphine 30 mg oral solution administered. Patient repositioned and offered toileting with no result. -- Susan Smith, RN
Yesterday 1500	Patient reports pain improved but still 9/10. Morphine 30 mg oral solution administered. -- Susan Smith, RN
Yesterday 1700	Patient reports pain improved but still 8/10. Morphine 30 mg oral solution administered. Refuses dinner tray or oral fluids. Denies nausea, states "I'm just not hungry." ----------------------------- Susan Smith, RN

Yesterday 1800	Updated hospice services on patient condition before end of my shift and asked for additional dose of pain medication to get patient through the night. Orders received for Morphine 40 mg solution and administered. Patient resting comfortably. -- Susan Smith, RN
Yesterday 2100	Patient awoke moaning and complained of pain 10/10. Morphine 40 mg oral solution administered. ------------------------------ Norma Notham, RN
Yesterday 2330	Patient sleeping. RR 6. --------------- Norma Notham, RN
Today 0300	Patient moaning. Mom at bedside and requests pain medication. RR 10. Morphine 40 mg oral solution administered. ------------------ Norma Notham, RN
Today 0500	Patient no longer verbally responsive. Occasionally moaning. RR 9. CPOT pain scale 4 out of 8. Patient demonstrating air hunger. O2 sat 85% with O2 via nasal cannula on at 6L/min. Morphine 30 mg oral solution administered. -------------- Susan Smith, RN
Today 0600	Patient continued to be nonverbally responsive with mumbling and moaning and occasional "reaching out" with her hands. RR 6. CPOT pain scale remains 4 out of 8. Patient continues to demonstrate air hunger. O2 sat 82% with O2 via nasal cannula on at 6L/min. Morphine 30 mg oral solution administered. -- Susan Smith, RN

Continue

LABS-DIAGNOSTICS



Labs-Diagnostics

Patient Name: Laura C. Anderson **DOB:** 04/16/19xx **MR#:** 0912

Arterial Blood Gases (ABG)				
Date	On admission		Units	Reference Range
pH	7.34		units	7.35-7.45
$PaCO_2$	58		mmHg	35-45
PaO_2	78		mmHg	80-100
HCO_3	32		mmol/L	22-26

IMAGING

Not available

HEALTH CARE DIRECTIVES

The iPad shows a copy of Laura's completed Advance Directive(s). See Appendix A.

DEATH MANAGEMENT PROTCOL

Death Management Protocol

DEATH MANAGEMENT PROTOCOL

1. Notify primary MD/Covering MD of patient's death.
    a. Only physicians, coroners, medical examiners or deputy medical examiners may pronounce death. A nurse, physician's assistant, paramedic or emergency medical technician may not pronounce a person dead and may not be listed on the Notice of Removal Form as a pronouncer of death.
    b. A registered nurse or licensed practical nurse may report observations that indicate an apparent death to a physician by telephone.
    c. The nurse should report to the physician immediately upon observation of the apparent death. The physician may then exercise professional judgment in pronouncing the individual dead.
        i. There should be no unnecessary delay in reporting to the physician. The nurse should record the information given to the physician and the physician's response in the person's medical record.
        ii. The date and time of death that is recorded in the medical record must reflect the date and time of the pronouncement of death by the physician, coroner, deputy coroner, medical examiner or deputy medical examiner. This is the same date and time of death that must be placed on the death certificate.

2. If a patient dies while in restraints or seclusion, is on one or more psychotropic meds, or is a suspected suicide, the death must be reported within 24 hours to the Department of Health and Human Services using the Patient Death Determination form.
    a. Scene Preservation
        i. If a coroner or medical examiner determines that a case requires an actual scene investigation it is important that no one inadvertently alters potential evidence at the death scene.
        ii. The coroner or medical examiner will determine if the body may be moved or removed, if the family or others may enter the death scene, and what, if any, of the items at the death scene should be preserved.
        iii. Any medical device attached to or introduced into the body should be left in its original position. The coroner or medical examiner will need to document all of the medical intervention rendered. This information is important for the pathologist who performs the autopsy and is especially important for trauma cases, no matter how long the person has been in the facility.

3. Notify STATLINE of death (1-866-894-2676). The Eye Bank will determine medical suitability for potential tissue/eye donation.
    a. RN/Recovery Coordinator may talk with family regarding potential tissue donation after suitability is determined.
    b. Complete consent for tissue donation with legal next of kin if applicable

4. Notify family – ensure accurate contact number and name before disclosing information

5. Notify spiritual care – call on-call chaplain

6. Determine if patient is a Medical Examiner's case. Call the County Medical Examiner and document in EMR. Discuss with police if evidence needs to be preserved in the following conditions:
(a) All deaths in which there are unexplained, unusual or suspicious circumstances.
(b) All homicides.
(c) All suicides.
(d) All deaths following an abortion.
(e) All deaths due to poisoning, whether homicidal, suicidal or accidental.
(f) All deaths following accidents, whether the injury is or is not the primary cause of death.
(g) When there was no physician, or accredited practitioner of a bona fide religious denomination relying upon prayer or spiritual means for healing, in attendance within 30 days preceding death.
(h) When a physician refuses to sign the death certificate.

7. Notify House Supervisor. Let them know if Medical Examiner, Autopsy and/or tissue/eye recovery involved.

8. Obtain the morgue cart from the morgue.

9. Complete the Notice of Removal of Human Corpse form and take to ED Registration.

10. Take body to morgue
    a. Place body in the cooler on the morgue cart with pillow under patient's head.
    b. If autopsy is requested/ordered, place the "Autopsy pending sheet" over the body.
    c. Body can only be left in the morgue for 24 hours. Inform legal next of kin that the decision on the funeral home must be made within 24 hours of death.

11. Notify the funeral home when the body is in the morgue. (Notify them if patient weighs > 300 lb/136 kg).
    a. If tissue recovery and/or autopsy will occur, let the Funeral Home know they will receive a second call when the body is ready to be picked up.

Guidelines for Tissue/Eye Donation or Autopsy Cases

1. Cooling procedure for Tissue Donor
    a. Nothing is required if body is placed in morgue cooler

2. Cooling procedure for Eye Donor. After the family has left:
    a. Gently irrigate both eyes with sterile saline
    b. Gently close the eyelids with gloved fingers; apply a cool compress of saline soaked gauze over the closed eyelids. Ensure the gauze covers the lid line.
    c. Elevate the head to decrease chances of bleeding/bruising and apply a light ice pack over closed eyelids.
    d. Document the date/time eye care was completed on the ice pack
    e. Cover patient with sheet and transport to the morgue. (Eye bank will coordinate all recovery details.)

3. Autopsy Guidelines if applicable: Place "autopsy pending" sheet on body
    a. "Medical Examiner ordered" requires no family consent. The Medical Examiner makes all arrangements including the release of the body to the funeral home.
    b. Physician requested: Complete the Permission for Postmortem Examination form. Next of kin or POA signature is required. Contact pathology for a post mortem examination.
    c. Family requested: Arrangements and payments are their responsibility.

Continue

SCANNER

Use this to scan scenario QR codes.

EXIT

When this tab is tapped, the iPad reads, "Are you sure you want to exit? All data will be lost."

- If "No" is selected, the iPad will return to the tabbed content.
- If "Yes" is selected, the iPad will let the student(s) exit and prompt them to complete an embedded 3-5 minute survey.

STATE 1

CARE FOR DECEASED PATIENT AND FAMILY MEMBER

- Patient Overview
  - Patient has just died as student enters the room. Mother is at bedside crying.
- Expected Student Behaviors
  - Introduce themselves to mother
  - Communicate therapeutically with mom and provide comfort
  - Call for chaplain
  - Complete various RN-related tasks associated with a patient's death using the simulated facility's "death management protocol" including:
  - Postmortem care
  - Notification of the physician and document date and time of death
  - Notification of house supervisor, funeral home and STATLINE for potential tissue donation
  - Recognition of when Scene Preservation is required, including calling the coroner and completion of the "Patient Death Determination" form
    - A printable version of this form is located in Appendix B.
  - Initiation of organ/tissue donation procedures such as cooling procedure for eye donor (note: advance directives include organ and tissue donation wishes)
  - Determine if autopsy guidelines are applicable (note: advance directives include autopsy wishes, but physician may request and autopsy or medical examiner may order an autopsy)
  - Preparation of body for morgue and completion of "Removal of Human Corpse" form
    - A printable version of this form is located in Appendix C.
- Technician Prompts
  - Patient: Not required since patient has just died.

    - Mother: Technician can role play Jane, the patient's mother, who is crying at the bedside.
        - Mother responses can include:
            - "She's too young to die!"
            - "Why did God do this?"
            - "Why do you have to call the coroner?"
            - "What does a coroner do?"
            - "She's perfect. I don't want anything cut out of her."
            - "I don't want someone looking out of her eyes."
            - "I want an autopsy performed."
- Possible Facilitator Questions
    - How can you promote a healthy grieving process for Laura's mother?
    - How will you prioritize your tasks on the protocol after death has occurred?
    - When does the Wisconsin Department of Health and Human Services need to be notified using the Patient Death determination form?
    - When is a Medical Examiner/coroner required?
    - When is Scene Preservation required?
    - Outline the steps required for Organ/Tissue Donation.
    - Whose wishes are followed for organ donation if the family doesn't agree?
    - When is an autopsy performed?
    - When is the Notice of Removal of Human Corpse required to be completed?
- Tabbed iPad Prompts and Content Changes
    - After the **QR Code: Facilitator** is scanned (at the end of Prebrief and prior to entering the patient's room for the first time), two new iPad tabs automatically appear.
    - Those new tabs are:
        - Patient Death Determination Form
        - Removal of a Human Corpse

PATIENT DEATH DETERMINATION FORM

The iPad shows a copy of a “Client/Patient/Resident Death Determination” form.

- A printable copy is located in Appendix B.

NOTICE OF REMOVAL OF HUMAN CORPSE

The iPad shows a copy of a “Notice of Removal of a Human Corpse from a Facility” form.

- A printable copy is located in Appendix C.

EXIT

When the Exit tab is tapped (students are not prompted to this), the iPad reads, “Scenario objectives have been met. Are you sure you want to exit the game?”

- If “No” is selected, the iPad automatically returns to the tabbed content area.
- If “Yes” is selected, the iPad will let the student(s) exit and prompt them to complete and embedded 3-5 minute survey

DEBRIEF

Nothing needed from the iPad.

QUESTIONS

1. How did you feel this scenario went?
2. Review understanding of learning objective: Communicate effectively and compassionately with the patient, family, and health care team members about end-of-life issues.
    a. What therapeutic techniques did you utilize with Laura's mother to assist her to cope with Laura's death? Were they effective?
    b. If you could "do over," would you say anything differently to Laura or her mom?
3. Review understanding of learning objective: Recognize one's own attitudes, feelings, values, and expectations about death and the individual, cultural, and spiritual diversity existing in these beliefs and customs.
    a. What did you learn about your own attitudes, feelings, values and expectations about death while caring for a patient who has just died?
4. Review understanding of learning objective: Demonstrate respect for the patient's views and wishes during end-of-life care.
    a. How did you advocate for Laura's wishes after she died?
5. Review understanding of learning objective: Apply legal and ethical principles in end-of-life care, recognizing the influence of personal values, professional codes, and patient preferences.
    a. Outline the basic RN responsibilities when an assigned patient dies.
    b. Are you surprised at the amount of paperwork required by the nurse when their patient dies?
    c. Explain when a coroner is required to be on scene.
    d. Explain when an autopsy is required.
    e. Explain "Scene Preservation" and when it is required.
    f. Review the MAR. Did the night shift nurse administer Morphine correctly to Laura?

g. If the night shift nurse was sued by Laura's family, do you think she would be found negligent? Why or why not?

h. What is the "rule of double effect" and how does it apply to this case?

6. Review understanding of learning objective: Incorporate spiritual health during end-of-life care

   a. How did you incorporate spiritual resources for Laura's mother at Laura's death?

7. Review understanding of learning objective: Explain the processes associated with organ donation

   a. Explain the basic process a RN must follow when organ/tissue transplantation occurs.

8. Tie the scenario back to the nursing process in a large group discussion. Concept mapping can be used to facilitate discussion.

   a. Identify priority nursing problems you identified for Laura's mother, Jane.

   b. Create a goal for each nursing problem you identified.

   c. Discuss potential focused assessments for each nursing problem.

   d. Discuss priority nursing interventions for each nursing diagnosis.

   e. Re-evaluate the simulation in terms of the nursing process; what was actually accomplished? What could be improved in the future?

9. Summary/Take Away Points

   a. "Today you cared for a patient who had just passed away and her mother, who was at the bedside. You completed the "Death Protocol" for that facility. What is one thing you learned from participating in this scenario that you will take with you into your nursing practice? (Each student must share something different from what others share.)

NOTE: Debriefing technique is based on INASCL Standards for Debriefing and NLN Theory-Based Debriefing by Dreifuerst.

SURVEY

Print this page and provide to students.

Students, please complete a brief (2-3 minute) survey regarding your experience with this ARISE simulation. There are two options:

1. Use QR Code: Survey
    a. Note: You will need to download a QR Code reader/scanner onto your own device (smartphone or tablet). There are multiple free scanner apps available for both Android and Apple devices from the app store.
    b. This QR Code will not work in the ARIS app.

2. Copy and paste the following survey link into your browser.
    a. https://ircvtc.co1.qualtrics.com/SE/?SID=SV_6Mwfv98ShBfRnBX

APPENDIX A

Advance Directive

including Power of Attorney for Health Care

Overview

This is a legal document, developed to meet the legal requirements for Wisconsin. This document provides a way for a person to create a Power of Attorney for Health Care and other documentation that will meet the basic requirements for this state.

This advance directive allows you to appoint another person and alternate people to make your health care decisions if you become unable to make these decisions for yourself. The person you appoint is called your **health care agent**. This document gives your health care agent authority to make your decisions *only when you have been determined incapable by your physicians to make them.* It does not give your health care agent any authority to make your financial or other business decisions. In addition, it does not give your health care agent authority to make certain decisions about your mental health treatment.

Before completing this document, take time to read it carefully. **It also is very important that you discuss your views, your values, and this document with your health care agent.** If you do not closely involve your health care agent, and you do not make a clear plan together, your views and values may not be fully respected because they will not be understood.

If you want to document your views about future health care, but do not want to or cannot use this advance directive, ask your health organization or attorney for advice about alternatives.

This is an advance directive for:

Name Laura C. Anderson Date of Birth 4/16/19xx

Telephone (Home)________ (Work) ________ (Cell) 555-0123

Address 100 Main Street

City Any Town State/ZIP WI 55555

January, 2014 For additional copies visit: www.honoringchoiceswi.org.

The name "Honoring Choices Wisconsin" is used under license from the Twin Cities Medical Society Foundation.

1

NOTICE TO PERSON MAKING THIS DOCUMENT

YOU HAVE THE RIGHT TO MAKE DECISIONS ABOUT YOUR HEALTH CARE. NO HEALTH CARE MAY BE GIVEN TO YOU OVER YOUR OBJECTION, AND NECESSARY HEALTH CARE MAY NOT BE STOPPED OR WITHHELD IF YOU OBJECT.

BECAUSE YOUR HEALTH CARE PROVIDERS IN SOME CASES MAY NOT HAVE HAD THE OPPORTUNITY TO ESTABLISH A LONG-TERM RELATIONSHIP WITH YOU, THEY ARE OFTEN UNFAMILIAR WITH YOUR BELIEFS AND VALUES AND THE DETAILS OF YOUR FAMILY RELATIONSHIPS. THIS POSES A PROBLEM IF YOU BECOME PHYSICALLY OR MENTALLY UNABLE TO MAKE DECISIONS ABOUT YOUR HEALTH CARE.

IN ORDER TO AVOID THIS PROBLEM, YOU MAY SIGN THIS LEGAL DOCUMENT TO SPECIFY THE PERSON WHOM YOU WANT TO MAKE HEALTH CARE DECISIONS FOR YOU IF YOU ARE UNABLE TO MAKE THOSE DECISIONS PERSONALLY. THAT PERSON IS KNOWN AS YOUR HEALTH CARE AGENT. YOU SHOULD TAKE SOME TIME TO DISCUSS YOUR THOUGHTS AND BELIEFS ABOUT MEDICAL TREATMENT WITH THE PERSON OR PERSONS WHOM YOU HAVE SPECIFIED. YOU MAY STATE IN THIS DOCUMENT ANY TYPES OF HEALTH CARE THAT YOU DO OR DO NOT DESIRE, AND YOU MAY LIMIT THE AUTHORITY OF YOUR HEALTH CARE AGENT. IF YOUR HEALTH CARE AGENT IS UNAWARE OF YOUR DESIRES WITH RESPECT TO A PARTICULAR HEALTH CARE DECISION, HE OR SHE IS REQUIRED TO DETERMINE WHAT WOULD BE IN YOUR BEST INTERESTS IN MAKING THE DECISION.

THIS IS AN IMPORTANT LEGAL DOCUMENT. IT GIVES YOUR AGENT BROAD POWERS TO MAKE HEALTH CARE DECISIONS FOR YOU. IT REVOKES ANY PRIOR POWER OF ATTORNEY FOR HEALTH CARE THAT YOU MAY HAVE MADE. IF YOU WISH TO CHANGE YOUR POWER OF ATTORNEY FOR HEALTH CARE, YOU MAY REVOKE THIS DOCUMENT AT ANY TIME BY DESTROYING IT, BY DIRECTING ANOTHER PERSON TO DESTROY IT IN YOUR PRESENCE, BY SIGNING A WRITTEN AND DATED STATEMENT OR BY STATING THAT IT IS REVOKED IN THE PRESENCE OF TWO WITNESSES. IF YOU REVOKE, YOU SHOULD NOTIFY YOUR AGENT, YOUR HEALTH CARE PROVIDERS, AND ANY OTHER PERSON TO WHOM YOU HAVE GIVEN A COPY. IF YOUR AGENT IS YOUR SPOUSE OR DOMESTIC PARTNER AND YOUR MARRIAGE IS ANNULLED OR YOU ARE DIVORCED OR THE DOMESTIC PARTNERSHIP IS TERMINATED AFTER SIGNING THIS DOCUMENT, THE DOCUMENT IS INVALID.

YOU MAY ALSO USE THIS DOCUMENT TO MAKE OR REFUSE TO MAKE AN ANATOMICAL GIFT UPON YOUR DEATH. IF YOU USE THIS DOCUMENT TO MAKE OR REFUSE TO MAKE AN ANATOMICAL GIFT, THIS DOCUMENT REVOKES ANY PRIOR RECORD OF GIFT THAT YOU MAY HAVE MADE. YOU MAY REVOKE OR CHANGE ANY ANATOMICAL GIFT THAT YOU MAKE BY THIS DOCUMENT BY CROSSING OUT THE ANATOMICAL GIFTS PROVISION IN THIS DOCUMENT.

DO NOT SIGN THIS DOCUMENT UNLESS YOU CLEARLY UNDERSTAND IT.

IT IS SUGGESTED THAT YOU KEEP THE ORIGINAL OF THIS DOCUMENT ON FILE WITH YOUR PHYSICIAN.

Part 1: My Health Care Agent

If I am no longer able to make my own health care decisions, this document names the person I choose to make these choices for me. This person will be my health care agent. This person will make my health care decisions when I am determined to be incapable of making health care decisions as provided under Wisconsin law. I understand that it is important for my health care agent and me to have ongoing discussions about my health and health care choices.

When selecting someone to be your health care agent, choose someone who knows you well, who you trust, who is willing to respect your views and values, and who is able to make difficult decisions in stressful circumstances. Often family members are good choices, but not always. Choose someone who will closely follow what you want and will be a good advocate for you. Take time to discuss this document and your views with the person(s) you choose to be your health care agent(s).

Your health care agent must be at least 18 years old and may not be one of your health care providers, or an employee of your health care provider, unless he or she is a close relative. You may also designate an alternate and second alternate health care agent.

The person I choose as my health care agent is:

Name ________________________ Relationship ________________________

Telephone (Home)______________ (Work) ______________ (Cell) ______________

Address ____

City ____________________________ State/ZIP ______________________

If this health care agent is unable or unwilling to make these choices for me, **then my next choice for a health care agent is:**

Second choice (alternate health care agent):

Name ________________________ Relationship ________________________

Telephone (Home)______________ (Work) ______________ (Cell) ______________

Address ____

City ____________________________ State/ZIP ______________________

If this alternate health care agent is unable or unwilling to make these choices for me, **then my next choice for a health care agent is:**

Third choice (2nd alternate health care agent):

Name ________________________ Relationship ________________________

Telephone (Home)______________ (Work) ______________ (Cell) ______________

Address ____

City ____________________________ State/ZIP ______________________

[X] Check here if you do not have an agent, and wish for your physician to follow the instructions below.

3

Part 2: General Authority of the Health Care Agent

I want my health care agent to be able to do the following:
*Draw a line through (e.g., ~~Arrange for~~) anything listed below that you do **not** want your health care agent to do.*

- Make choices for me about my medical care or services, like tests, medicine, and surgery. If treatment already has been started, my health care agent can keep it going or have it stopped based on my stated instructions or my best interests.
- Interpret any instruction I have given in this form or given in other discussions according to my health care agent's understanding of my wishes and values.
- Review and release my medical records and personal files as needed for my medical care.
- Arrange for my medical care and treatment in Wisconsin or any other state, as my health care agent thinks is appropriate.
- Determine which health care professionals and organizations provide my medical treatment.
- Make decisions about organ and tissue donation (anatomical gifts) after my death according to my known wishes or values.

Limitations on Mental Health Treatment
Pursuant to Wisconsin statutes my health care agent may not admit or commit me on an inpatient basis to an institution for mental diseases, an intermediate care facility for persons with an intellectual disability, a state treatment facility or a treatment facility. My health care agent may not consent to experimental mental health research or psychosurgery, electroconvulsive treatment or drastic mental health treatment procedures for me.

4

To complete the next 3 sections:
Initial or check the box beside one statement in each section. If you do not mark any box in a section, your choice is "no" according to Wisconsin statute. This means if you do not indicate a choice, a court may make such a decision and not your health care agent.

1. Admission to a Nursing Home or Community-Based Residential Facility

My health care agent may admit me to a nursing home or community-based residential facility for short-term stays for recuperative care or respite care.

Agent authority to admit me to a nursing home or community-based residential facility for the purpose of long-term care:

[ ] **Yes,** my health care agent has authority, if necessary, to admit me to a nursing home or community-based residential facility for a long-term stay. This is subject to any limits I set in this document.

[X] **No,** my health care agent does not have authority to admit me to a nursing home or community-based residential facility for a long-term stay.

Unless I choose "yes," I can be admitted to a long-term care facility for a long-term stay only with a court order.

2. Withholding or Withdrawal of Feeding Tube

[ ] **Yes**, my health care agent has authority to have a feeding tube withheld or withdrawn from me, unless my physician advises that, in his or her professional judgment, the withholding or withdrawing will cause me pain or discomfort. This is subject to any limits I set in this document.

[X] **No,** my health care agent does not have authority to have a feeding tube withheld or withdrawn from me.

Unless I choose "yes," a feeding tube can be withdrawn or withheld from me only with a court order.

3. Health Care Decisions during Pregnancy

[ ] **Yes,** my health care agent has authority to make health care decisions for me if I am pregnant. This is subject to any limits I set in this document.

[ ] **No,** my health care agent does not have authority to make health care decisions for me if I am pregnant.

Unless I choose "yes," health care decisions during pregnancy can be made for me only with a court order.

[X] **Does not apply**. I am either a male or no longer capable of becoming pregnant.

5

Part 3: Statement of Desires, Special Provisions, or Limitations

You are not required to provide any instructions or make any selections in this section.

My health care agent shall make decisions consistent with my stated desires and values. He or she is subject to any special instructions or limitations that I may list here. The following are some specific instructions for my health care agent and/or physician providing my medical care. If there are conflicts among my known values and goals, I want my health care agent to make the decision that would best represent my values and preferences. If I require treatment in a state that does not recognize this advance directive, or my health care agent cannot be contacted, I want the instructions to be followed based on my common law and constitutional right to direct my own health care.

If you choose **not** to provide any instructions, your health care agent will make decisions based on your oral instructions or what is considered your best interest. If you choose **not** to provide any instructions, it is recommended that you draw a line and write "no instructions" across the section.

Instructions Regarding Life-Prolonging Treatments

Initial or check the box beside the statement or statements you agree with.

If I reach a point where there is reasonable medical certainty that I will not recover my ability to know who I am, who my family and friends are, or where I am, I want to be kept comfortable and clean, and I want my health care agent to:

[X] Stop or do not start medical treatments that might be used to prolong my life. Treatments I would not want if I were to reach this point include but are not limited to: feeding tubes including intravenous (IV) hydration, respirator/ventilator, and cardiopulmonary resuscitation (CPR). If I suffer this type of condition, in my view, the potential benefits of supportive medical treatments are outweighed by the burdens of those treatments.

[ ] Continue or start feeding tubes including intravenous (IV) hydration if needed, but stop all other medical treatments including, but not limited to, a respirator/ventilator and cardiopulmonary resuscitation (CPR).

[ ] I want my agent to be able to make decisions for me about life-sustaining treatment.

[X] Follow my instructions as provided below.

Pain and Comfort

Initial or check the box beside this statement if you agree.

[X] If I reach a point where efforts to prolong my life are stopped, I still want medical treatments and nursing care that will make me comfortable.

The following are important to me for comfort (If you don't write specific wishes, your physician and nurses will provide the best standard of care possible):

Medications for pain and nausea to keep me comfortable

6

Cardiopulmonary Resuscitation (CPR)
My CPR choice listed below may be reconsidered by my health care agent in light of my other instructions or new medical information, if I become incapable of making my own decisions. If I do not want CPR attempted, my physician should be made aware of this choice. **If I indicate below that I do not want CPR attempted, this choice, in itself, will not stop emergency personnel from attempting CPR in an emergency.**

Initial or check the box beside the statement you agree with.

[ ] I want CPR attempted ***unless*** my physician determines any one of the following:

- I have an incurable illness or injury and am dying; OR
- I have no reasonable chance of survival if my heart stops; OR
- I have little chance of long-term survival if my heart stops and the process of resuscitation would cause significant suffering.

[X] I do not want CPR attempted if my heart stops. To the extent possible, I want to allow a natural death.

Other instructions or limitations I want my health care agent to follow:

No feeding tube

No IVs

When I am nearing my death and cannot communicate, I want my friends and family to know I have the following thoughts and feelings:

I love them. It's time to let me go.

If I am nearing my death, I want the following:
List the type of care, ceremonies, etc. that would make dying more meaningful for you.

Last rites by my priest. Saying of rosary at my bedside.

Read Bible verses to me.

Person or people I want my health care agent to include when making health care decisions:
I ask that my health care agent make a reasonable effort to include the following person or people in my health care decisions if there is time: none

7

Spirituality and/or Religious Affiliation
I am of the Catholic faith and am a member of the St. Patrick's congregation, parish, synagogue, or worship group in (city) Small Town.
The telephone number of the congregation, parish, synagogue, or worship group is: ?.
Please attempt to notify someone there if I am unable to give authorization to do so.

☐ I am not religious or spiritually affiliated.

Upon My Death
After my death the following are my instructions. If my health care agent does not have authority to make these decisions, I ask that my next of kin and physician follow these requests if possible.

- **Donation of my Organs or Tissue (Anatomical Gifts)**

Examples of organs are kidney, liver, heart, and lungs. Examples of tissue are eyes, skin, bones, and heart valves. Initial or check the box beside the one statement you agree with.

☒ After I die, I wish to donate any parts of my body that may be helpful to others.
To make your wishes legally effective, register at www.donorregistry.wisconsin.gov

☐ After I die, I wish to donate **only** the following organs and tissue: ____________________

☐ I do not wish to donate any part of my body.

- **Autopsy**

Initial or check the box beside one choice, or both A and B.

☐ A. I would accept an autopsy if it can help my blood relatives understand the cause of my death or affect their own health care choices.

☐ B. I would accept an autopsy if it can help advance medicine or medical education.

☒ C. I do not want an autopsy performed on me.

8

Part 4: Making the Document Legal

This document must be signed and dated **in the presence of two witnesses** who meet the qualifications explained below.

My Signature

I am thinking clearly, I agree with everything that is written in this document, and I have completed this document willingly.

My signature Laura C. Anderson Date Today

If I cannot sign my name, I ask the following person to sign for me ____________

Signature of the person who I asked to sign this document for me ____________

Statement of Witnesses

By signing this document as a witness, I certify I am:

- At least 18 years old.
- Not related by blood, marriage, domestic partnership, or adoption to the person signing this document.
- Not a health care agent appointed by the person signing this document.
- Not directly financially responsible for this person's health care.
- Not a health care provider directly serving the person at this time.
- Not an employee (other than a social worker or chaplain) of a health care provider directly serving the person at this time.
- Not aware that I am entitled to or have a claim against the person's estate.

I know this to be the person identified in the document. I believe him or her to be of sound mind and at least 18 years old. I personally witnessed him or her sign this document, and I believe that he or she did so voluntarily.

Witness Number One:

Signature Jane Smith Date Today

Print name Jane Smith

Address 100 Hospital Drive

City Any Town State/ZIP WI 55555

Witness Number Two:

Signature John Doe Date Today

Print name John Doe

Address 100 Hospital Drive

City Any Town State/ZIP WI 55555

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Part 5: What to Do Next

Now that you have completed your advance directive, you also should take the following steps:

- Talk to the person you named as your health care agent, if you haven't already done so. Make sure he or she feels able to perform this important job for you in the future.
- Give your health care agent a copy of this document.
- Talk to the rest of your family and close friends who might be involved if you have a serious illness or injury. Make sure they know who your health care agent is, and what your wishes are.
- Give a copy of this advance directive to your physician. Make sure your wishes are understood and will be followed.
- Keep a copy of this advance directive where it can be easily found.
- If you go to a hospital or nursing home, take a copy of this advance directive and ask that it be placed in your medical record.
- Review your health care wishes every time you have a physical exam or whenever any of the "Five D's" occur:

    Decade – when you start each new decade of your life.

    Death – whenever you experience the death of a loved one.

    Divorce – when your agent is your spouse or your domestic partner and your marriage is annulled or you are divorced or your domestic partnership is terminated after signing this document, the document is invalid. A new document must then be completed.

    Diagnosis – when you are diagnosed with a serious health condition.

    Decline – when you experience a significant decline or deterioration of an existing health condition, especially when you are unable to live on your own.

- If your wishes change, tell your health care agent, your family, your physician, and everyone who has copies of this advance directive. It would be necessary that you complete a new advance directive to reflect your current wishes.
- Cut out the card on the following page, fill it in, fold it and put it in your wallet.

Copies of this document have been given to:

Primary (Main) Health Care Agent

Name ______________________________

Alternate Health Care Agent

Name ______________________________

2nd Alternate Health Care Agent

Name ______________________________

Health Care Professional/Organization

Name Hospital Central Telephone 555-555-0100

Name ______________ Telephone ______________

Name ______________ Telephone ______________

Need Assistance?

If you need assistance in completing this document, you may contact:

FOR SIMULATION PURPOSES ONLY

I HAVE AN ADVANCE DIRECTIVE	Card holder information
Name Laura C. Anderson	Address 100 Main Street
Honoring Choices WISCONSIN	City/state/ZIP Any Town, WI 55555
AN INITIATIVE OF THE WISCONSIN MEDICAL SOCIETY	Phone 555-555-0123 Date of birth 9/16/19XX
The name "Honoring Choices Wisconsin" is used under license from the Twin Cities Medical Society Foundation.	My advance directive is filed at Hospital Central
	Address 100 Hospital Drive
	City/state/ZIP Any Town, WI 55555
	Phone 555-555-0100
	My health care agent is none
	Address
	City/state/ZIP
	Phone

11

APPENDIX B

DEPARTMENT OF HEALTH SERVICES
Division of Quality Assurance
F-62470 (04/2012)

STATE OF WISCONSIN
Chapters 48.60(5)(a), 50.035(5), and 51.64(2), Wis. Stats.
Page 1 of 6

CLIENT / PATIENT / RESIDENT DEATH DETERMINATION

USE OF FORM

- **For a listing of facilities and programs who should utilize this form, go to page 5.**
- Reporting of certain deaths to the Department of Health Services is required by Wisconsin State Statute. This form should be used for this purpose. Failure to report these deaths to the Department may result in a citation of noncompliance by the Department. The information obtained will be used for investigative and statistical purposes and the personally identifiable information will be available only to those persons authorized to access treatment records.
- If you have any questions regarding this form, call **(608) 261-0658**.

INSTRUCTIONS

1. A client, patient, or resident death must be reported to the Department within 24 hours after the death or upon learning of the death if there is cause to believe that the death was related to the use of a **physical restraint / seclusion, psychotropic medications, or suicide.**
2. When in doubt about whether the death was due to physical restraints / seclusion, psychotropic medications, or suicide, report the death.
3. Attach a copy of the progress notes or other documentation which provide additional information to determine if there is reasonable cause to believe that the death was due to the use of physical restraints / seclusion, psychotropic medications, or suicide.
4. Submit the completed form via fax to the Division of Quality Assurance (DQA) chief or director listed in the "DQA Reportable Death Contact Table" on page 5 of this form.

I. DETERMINATION

Name – **Deceased Client** (Last, First, MI)	Date - Birth	Sex ☐ M ☐ F	Date – Admission	Date – Death

Ethnicity (Check one.)	Is this death reportable to coroner / medical examiner?
☐ Black - Not Hispanic ☐ Asian or Pacific Islander ☐ American Indian / Alaska Native ☐ Hispanic - Mexican, Puerto Rican, Cuban ☐ White - Not Hispanic	☐ Yes ☐ No

Name – **Agency / Provider**		Certification / License Number	Provider Type No. (See page 2.)	
Address – Street Address	City	County	State	Zip Code

Name - **Client Emergency Contact Person**	Relationship	Telephone Number	
Address – Street Address	City	State	Zip Code

Name - **Individual Reporting**	Title	Telephone Number	
Address – Street Address	City	State	Zip Code

Name - **To Whom Reported**	Telephone Number	☐ Self Report ☐ Other:	Date Reported

Check "Yes" or "No" for each item in sections A - C. For assistance, see guidelines on pages 3 and 4.

A. Suicide

☐ Y ☐ N 1. Was there evidence that the client / patient / resident was having suicidal thoughts during the last month?
☐ Y ☐ N 2. Did the client / patient / resident make any suicide threats or statements during the last month?
☐ Y ☐ N 3. Did the client / patient / resident make a suicide attempt in the past year?
☐ Y ☐ N 4. Did the client / patient / resident give away personal possessions within the last month?
☐ Y ☐ N 5. Was the client / patient / resident found in a position or circumstance which might indicate the death was due to suicide; e.g., hanging, drowning, drug overdose, asphyxiation (being found in a car with the engine running), fall from a bridge or down stairs, a self-inflicted wound, a single car accident with good road conditions, self-immolation (burning)?

B. Psychotropic Medication

☐ Y ☐ N 1. Was the client / patient / resident on three or more psychotropic medications?
☐ Y ☐ N 2. Was the client / patient / resident on two or more psychotropics in the same class?

B. Psychotropic Medication *(continued)*

Y	N	#	Question
☐ Y	☐ N	3.	Did the physician discontinue a psychotropic medication within the last seven days?
☐ Y	☐ N	4.	Did the client / patient / resident refuse psychotropic medications within the last seven days?
☐ Y	☐ N	5.	Was the client / patient / resident changed to a different psychotropic medication within the last seven days?
☐ Y	☐ N	6.	Did the client / patient / resident's medical / psychiatric condition change in the last seven days, based on observed symptoms and behaviors? *(continued on next page)*
☐ Y	☐ N	7.	Did the client / patient / resident receive any drug(s) to which he / she has a known allergy or adverse drug reaction as documented in his / her record within the last seven days?
☐ Y	☐ N	8.	If the client / patient / resident was on Clozapine, did the known adverse reactions of this medication contribute to the death of the client?
☐ Y	☐ N	9.	Did the client / patient / resident present any signs which would indicate the possibility of neuroleptic malignant syndrome (NMS)?
☐ Y	☐ N	10.	Was a psychotropic medication given with no valid diagnosis for the drug?
☐ Y	☐ N	11.	If the client / patient / resident is a GERIATRIC CLIENT, was he / she on lithium? If "Yes", was lithium used in combination with haloperidol, another antipsychotic, neuromuscular blocker and / or antidepressant?
☐ Y	☐ N	12.	If the client / patient / resident is a GERIATRIC CLIENT, was he / she on a long acting benzodiazepine before therapy with a short acting benzodiazepine?
☐ Y	☐ N	13.	If the client / patient / resident is a GERIATRIC CLIENT, was he / she on Xanax and did he / she experience a sudden withdrawal of this medication within the last seven days?

C. Physical Restraints and Seclusion

Y	N	#	Question
☐ Y	☐ N	1.	Did the client / patient / resident die while in restraint or seclusion?
☐ Y	☐ N	2.	Did the restraint / seclusion have a direct relationship to the client / patient / resident's death?
☐ Y	☐ N	3.	Did the client / patient / resident sustain any injury while in restraint or seclusion?
☐ Y	☐ N	4.	Was the client / patient / resident in a prone position when a physical restraint was used?

PROVIDER TYPE *(Enter applicable, corresponding number on page 1, line 3 --- "Provider Type Number.")*

1. Emergency Mental Health Srvc *(DHS 34)*
2. Outpatient Mental Hlth Clinic *(DHS 35)*
3. CCS - Persons w/Mental Hlth & Substance Use Disorders *(36)*
4. Mental Hlth Day Treatment Srvcs for Children *(DHS 40)*
5. Mental Hlth Inpatient - Adult / Adolescent *(DHS 61.71 / 61.79)*
6. Mental Hlth Day Treatment *(DHS 61.75))*
7. CSP for Persons w/Chronic Mental Illness *(DHS 63)*
8. Emergency Outpatient Srvc (DHS 75.05)
9. CSAS Medically Managed Inpatient Detox Srvc *(DHS 75.06)*
10. CSAS Medically Managed Residential Detox Srvc *(75.07)*
11. CSAS Ambulatory Detox Srvc (DHS 75.08)
12. CSAS Residential Intoxication Monitoring Srvc (DHS 75.09)
13. CSAS Medically Managed Inpatient Treatment Srvc *(DHS 75.10)*
14. CSAS Medically Managed Treatment Srvc *(DHS 75.11)*
15. CSAS Day Treatment Srvc *(DHS 75.12)*
16. CSAS Outpatient Treatment Srvc *(DHS 75.13)*
17. CSAS Transitional Residential Treatment Srvc *(DHS 75.14)*
18. CSAS Narcotic Treatment Srvc for Opiate Addiction *(DHS 75.15)*
19. Community Based Residential Facility *(DHS 83)*
20. Adult Family Home *(DHS 88)*
21. Nursing Home *(DHS132)*
22. Facility for the Developmentally Disabled *(DHS 134)*

REASON FOR REPORTING

Name - Individual Involved in Case	Title	Telephone Number	
SIGNATURE - Person Completing Form ➢	Title	Telephone Number	Date Signed

NURSING | LEVEL: 4

II. CLIENT / PATIENT DEATH DETERMINATION GUIDELINES

The following guidelines, which are not all-inclusive, are listed to assist the provider in determining if there is reasonable cause to believe the client / patient death may be due to the use of restraint / seclusion, the use of psychotropic medications, or suicide.

A. Suicide

Presence of one or more of the following risk factors in the client profile:

1. Clinical syndromes of depression, psychosis, impulsivity, and intoxication.
2. Symptomatic or psychological predictors such as hopelessness, recent losses along with the experience of loss, and panic levels of anxiety.
3. Demographic factors which put a client in a moderate or greater risk category for suicide; e.g., among the seriously mentally ill, male gender, previous suicide attempts, a recent (within the last six months) acute psychotic or affective episode, first decade and---particularly---the first five years of the illness, AODA problems.
4. Recent behaviors that suggest that the client is acting differently; e.g., making final plans, “tidying up” personal affairs, obtaining the means for suicide, seeking out help more often (often with no clear complaint).
5. Lethality: The client's mental intent to die or to kill oneself, including the individual's view of life after death and what relief or reward it offers; specificity and imminence of a suicide plan; availability and lethality of the means for suicide; the opportunity in the suicidal plan for rescue.
6. The absence of positive social supports or the presence of ones that are not helpful or that are harmful; e.g., critical, rejecting.

B. Psychotropic Medications

1. Psychotropic Medication: A psychotropic medication is any drug used to treat, manage, or control psychiatric symptoms or disordered behavior, including but not limited to antipsychotic, antidepressant, mood stabilizing, or antianxiety agents. Medications which may be used either for more general medical purposes or for their effect on psychiatric symptoms would be considered psychotropic medications when they were being used to obtain a psychiatrically related benefit.
2. Presence of one or more of the following psychotropic drug interactions and / or conditions in the client profile:
   a. Any anaphylactic reactions
   b. Tricyclic antidepressant overdose
   c. Lithium overdose
   d. Combination of any psychotropic medication(s) and alcohol
   e. Bone marrow suppression, especially with clozapine, but also with other neuroleptics and tricyclic antidepressants
   f. Hypertensive crisis with monoamine oxidase inhibitors (MAOIs)
   g. Cardiac arrhythmias as a result of an antidepressant medication
   h. Any drug overdose
   i. Any blood level of a drug higher than accepted therapeutic drug level
   j. After starting on antipsychotic medication, the client complains of an increased temperature and muscular rigidity
   k. Fatal heatstroke, especially if client is on Thorazine
   l. History of difficult to control epilepsy
   m. Jaundiced skin and sclera
   n. Psychotropic medications administered to clients in excess of the recommended geriatric doses which are listed in Appendix P of the Federal Long Term Care Regulations for Nursing Homes
   o. Any medication error in proximity to time of client death
3. Client experienced the following three operational criteria for a diagnosis of neuroleptic malignant syndrome (NMS).
   a. Hyperthermia: A high temperature in the absence of known etiology
   b. Severe extrapyramidal effects characterized by two or more of the following: lead-pipe muscle rigidity, pronounced cogwheeling, sialorrhea, oculogyric crisis, retrocollis, opisthotonos, trismus, dysphagia, choreiform movements, festinating gait, and flexorextensor posturing
   c. Autonomic dysfunction characterized by two or more of the following: hypertension, tachycardia, prominent diaphoresis, incontinence

   In retrospective diagnosis, if one of these three items (3a - 3c) has not been specifically documented, a probable diagnosis is still permitted if the remaining two criteria are clearly met and the client displays one of the following characteristic signs: clouded consciousness as evidenced by delirium, mutism, stupor or coma; leukocytosis (more that 15,000 white blood cells / mm); serum creatine kinase level greater than 1,000 IU / ml. (Source: The Manual of Clinical Psychopharmacology - 2nd Edition)

C. Physical Restraints and Seclusion

1. Presence of one or more of the following indicators:
   a. Client found suspended by / from restraint
   b. Client found sliding from bed / wheelchair / chair
   c. Client's neck / head found under / between side rails
   d. Client found in tipped wheelchair with a restraint intact
   e. Autopsy report indicates asphyxiation or possible asphyxiation

2. Position of actual restraint.
   a. Restraint under client's ribs exerting pressure
   b. Restraint across chest and conforming to body in a tight appearing fashion
   c. Restraint across throat area

3. Physical hold by staff utilized in proximity to time of death of client.

4. Resident found expired in seclusion / locked room.

5. Presence of one or more of the following physical signs:
   a. Discolored areas on skin
   b. Red markings on skin
   c. Swollen tongue

DQA Reportable Death Contact Table

No.	Provider Type	DHS Admin. Rule	License / Certification	Fax this Client / Patient Death Determination form to:
1	Emergency Mental Hlth Srvc	34	Certification	Chief, Behavioral Hlth Certification Section, **Fax (608) 261-0655**. For questions about reporting a death, call (608) 261-0658.
2	Outpatient Mental Hlth Clinic	35	Certification	Chief, Behavioral Hlth Certification Section, **Fax (608) 261-0655**. For questions about reporting a death, call (608) 261-0658.
3	CCS for Persons w/Mental Hlth & Substance Use Disorders	36	Certification	Chief, Behavioral Hlth Certification Section, **Fax (608) 261-0655**. For questions about reporting a death, call (608) 261-0658.
4	Mental Hlth Day Treatment Srvcs for Children	40	Certification	Chief, Behavioral Hlth Certification Section, **Fax (608) 261-0655**. For questions about reporting a death, call (608) 261-0658.
5	Mental Health Inpatient - Adult / Adolescent	61.71 / 61.79	Certification	Chief, Behavioral Hlth Certification Section, **Fax (608) 261-0655**. For questions about reporting a death, call (608) 261-0658.
6	Mental Health Day Treatment	61.75	Certification	Chief, Behavioral Hlth Certification Section, **Fax (608) 261-0655**. For questions about reporting a death, call (608) 261-0658.
7	CSP for Persons w/Chronic Mental Illness	63	Certification	Chief, Behavioral Hlth Certification Section, **Fax (608) 261-0655**. For questions about reporting a death, call (608) 261-0658.
8	Emergency Outpatient Srvc	75.05	Certification	Chief, Behavioral Hlth Certification Section, **Fax (608) 261-0655**. For questions about reporting a death, call (608) 261-0658.
9	CSAS Medically Managed Inpatient Detox Srvc	75.06	Certification	Chief, Behavioral Hlth Certification Section, **Fax (608) 261-0655**. For questions about reporting a death, call (608) 261-0658.
10	CSAS Medically Managed Residential Detox Srvc	75.07	Certification	Chief, Behavioral Hlth Certification Section, **Fax (608) 261-0655**. For questions about reporting a death, call (608) 261-0658.
11	CSAS Ambulatory Detox Srvc	75.08	Certification	Chief, Behavioral Hlth Certification Section, **Fax (608) 261-0655**. For questions about reporting a death, call (608) 261-0658.
12	CSAS Residential Intoxication Monitoring Srvc	75.09	Certification	Chief, Behavioral Hlth Certification Section, **Fax (608) 261-0655**. For questions about reporting a death, call (608) 261-0658.
13	CSAS Medically Managed Inpatient Treatment Srvc	75.10	Certification	Chief, Behavioral Hlth Certification Section, **Fax (608) 261-0655**. For questions about reporting a death, call (608) 261-0658.
14	CSAS Medically Managed Treatment Srvc	75.11	Certification	Chief, Behavioral Hlth Certification Section, **Fax (608) 261-0655**. For questions about reporting a death, call (608) 261-0658.
15	CSAS Day Treatment Srvc	75.12	Certification	Chief, Behavioral Hlth Certification Section, **Fax (608) 261-0655**. For questions about reporting a death, call (608) 261-0658.
16	CSAS Outpatient Treatment Srvc	75.13	Certification	Chief, Behavioral Hlth Certification Section, **Fax (608) 261-0655**. For questions about reporting a death, call (608) 261-0658.
17	CSAS Transitional Residential Treatment Srvc	75.14	Certification	Chief, Behavioral Hlth Certification Section, **Fax (608) 261-0655**. For questions about reporting a death, call (608) 261-0658.
18	CSAS Narcotic Treatment Srvc for Opiate Addiction	75.15	Certification	Chief, Behavioral Hlth Certification Section, **Fax (608) 261-0655**. For questions about reporting a death, call (608) 261-0658.
19	Community Based Residential Facility	83	License	DQA Regional Field Operations Director for the Region where your facility is located. See attached page with a list and map.
20	Adult Family Home	88	License	DQA Regional Field Operations Director for the Region where your facility is located. See attached page with a list and map.
21	Nursing Home	132	License	DQA Regional Field Operations Director for the Region where your facility is located. See attached page with a list and map.
22	Facility for the Developmentally Disabled	134	License	DQA Regional Field Operations Director for the Region where your facility is located. See attached page with a list and map.

For additional information, including copies of annual Act 336 Reports, contact:

Mark Hale, Chief
DQA / Bureau of Health Services / Behavioral Health Certification Section
Phone: (608) 264-9894
Fax: (608) 261-0655

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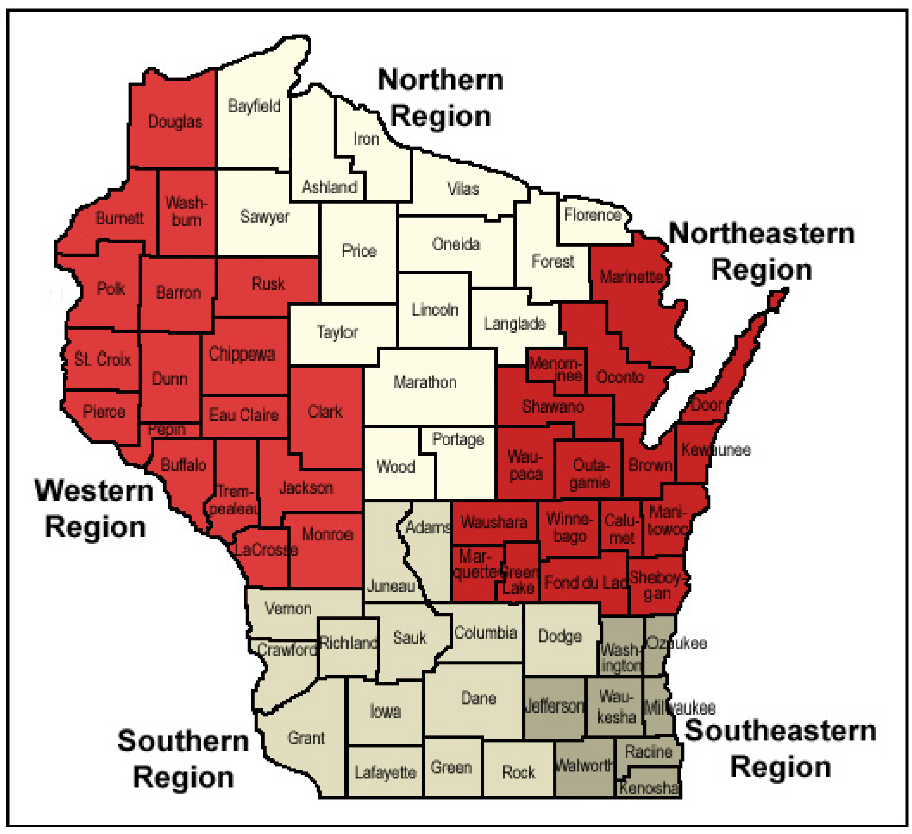

DQA Regional Field Operations Directors

Northeastern Regional Office - De Pere
Fax: 920-983-3201
For questions about reporting a death: 920-983-3185

Northern Regional Office – Rhinelander
Fax: 715-365-2815
For questions about reporting a death: 715-365-2800

Southeastern Regional Office – Milwaukee
Fax: 414-227-4139
For questions about reporting a death: 414-227-4563

Southern Regional Office – Madison
Fax: 608-266-7474
For questions about reporting a death: 608-266-8975

Western Regional Office – Eau Claire
Fax: 715-836-2535
For questions about reporting a death: 715-836-4753

APPENDIX C

DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-05043 PART 1 (Rev 09/13)

PART 1

STATE OF WISCONSIN
Chapter 69, Wis. Stats.
Page 1 of 3

NOTICE OF REMOVAL OF A HUMAN CORPSE FROM A FACILITY

Hospital / Nursing Home / Hospice Care

Items 1-31 of Part 1 and all items in Part 2 to be completed by the facility or hospice administrator (or a designee).
Items 32-38 to be completed by a Wisconsin licensed funeral director, coroner/medical examiner, or family member.

TYPE OR PRINT IN PERMANENT BLACK INK ONLY

1. DECEDENT'S CURRENT LEGAL NAME- First | Middle | Last | Suffix

AKA:

2. SEX | 3. AGE AT DEATH (include age and age unit) ☐ Years ☐ Months ☐ Days ☐ Hours ☐ Mins ☐ Stillbirth | 4. SOCIAL SECURITY NUMBER | 5. DATE PRONOUNCED DEAD | 6. TIME PRONOUNCED DEAD (0000-2359)

7. DEATH PRONOUNCED BY (Only professions listed may pronounce death. Check only one.)
☐ Physician ☐ Coroner/M.E. ☐ Deputy Coroner/M.E. ☐ Hospice R.N. (ONLY if 9 is Yes)

8. PRONOUNCER'S NAME

9. HOSPICE RESPONSIBLE FOR CARE? ☐ Yes ☐ No

10. HOSPICE NAME

11. HOSPITAL DEATH (Includes hospice patients)
☐ Inpatient ☐ DOA from NH ☐ DOA from Other
☐ Outpatient ☐ ER from NH ☐ ER from Other

12. OTHER PLACE OF DEATH (Complete this item if the death did not occur at a hospital. Includes hospice patients)
☐ Nursing Home ☐ Decedent's Residence ☐ Hospice Facility ☐ CBRF
☐ Residence Care Apt (RCAC) ☐ Adult Family Home (AFH) ☐ Other

13. FACILITY NAME (if applicable)

14. COUNTY OF DEATH

15. CITY, VILLAGE, OR TOWNSHIP OF DEATH
☐ City ☐ Village ☐ Township

16. ADDRESS OF DEATH

17. ZIP CODE

18. MEDICAL CERTIFIER INFORMATION
☐ **PHYSICIAN**
Physician with a valid Wisconsin physician license (not 1st year resident)
Physician with a temporary Wisconsin physician license
Other licensed physician working in a Veteran's Hospital
☐ **WISCONSIN CORONER/M.E. or DEPUTY CORONER/M.E.**

19. CERTIFIER'S NAME & TITLE – death certificate to be signed by:

20. CERTIFIER'S PHONE NUMBER

21. CERTIFIER'S FAX NUMBER

22. CERTIFIER'S FACILITY NAME

23. CERTIFIER'S MAILING ADDRESS

24. ALTERNATE CERTIFIER'S NAME

25. ALT. PHONE NUMBER

26. ALT. FAX NUMBER

COMMUNICABLE DISEASE ALERT: See PART 2 - PART 2 MUST be completed even if the decedent has none of the conditions listed
In accordance with Wis. Stat. s. 69.18(3)(g) and Administrative Rule DHS 135.04(3), the facility or hospice must complete Part 2 of this form at the time the body is removed from their facility. Part 2 of this form is to be completed and GIVEN TO THE PERSON REMOVING THE BODY AT THE TIME THE BODY IS REMOVED. Part 2 of this form is NOT to be transmitted to the local vital records office.

REPORTABLE DEATHS - (Per Wis. Stats. ss.30.67, 69.18, 157, 346.71, 350, and 979)
Prior to removal and embalming of body, you MUST notify the coroner or medical examiner if any of the following circumstances regarding the decedent's death apply: all homicides, suicides, or poisonings, all deaths following an accident/injury (includes any type of injury that occurred at any time if the injury significantly affected the health of the decedent), all deaths following an abortion procedure, all deaths involving a motor vehicle (includes snowmobiles, ATVs, boats, etc), all deaths with no physician or spiritual healer in attendance within 30 days, all deaths of correctional inmates, when the physician refuses to sign the death certificate, all deaths in which there are unexplained, unusual, or suspicious circumstances, all sudden deaths and all deaths reportable under county policies.

27. NOTIFICATION OF THE CORONER/MEDICAL EXAMINER REQUIRED? ☐ No ☐ Yes
(This form does NOT constitute notification of the Coroner or Medical Examiner)

28. STATE & COUNTY OF INCIDENT (required if 27 is Yes)

29. NAME OF STAFF PERSON COMPLETING THIS SECTION

30. **SIGNATURE** OF PERSON COMPLETING THIS SECTION

31. PHONE NUMBER

32. STATUS OF PERSON REMOVING BODY (Check one)
☐ Wisconsin Licensed Funeral Home Representative ☐ Coroner/M.E. (pursuant to a death investigation per ss. 979.01 and 979.10, Wis. Stats., for body storage or disposition)
☐ Family Disposition (Per Wisconsin Statutes section 69.18, an immediate family member removing a body must **personally** conduct the final disposition and is responsible for the preparation of the Notice of Removal and the preparation and filing of the Report for Final Disposition and Death Certificate)

33. FUNERAL DIRECTOR'S NAME & WI LICENSE NUMBER (or person acting as such)

34. FUNERAL HOME NAME (if applicable)

35. MAILING ADDRESS OF FUNERAL HOME (or of person acting as such)

36. **SIGNATURE** - FUNERAL DIRECTOR (or person acting as such)

37. DATE SIGNED

38. PHONE NUMBER

IMPORTANT NOTES

- The facility/hospice MUST send this form to the local registrar (Register of Deeds or Milwaukee City Health Office or West Allis City Health Office) within 24 hours of death (Wis. Stat. s 69.18). The facility/hospice should keep one copy of the form for the medical chart. The funeral director (or other person removing the body) also requires a copy. For hospice deaths, the funeral director may fax the Notice of Removal to the hospice organization for filing. See instructions on time extension.
- This form is not required for stillborns, but may be used to document release of the remains. Hospital staff and funeral directors must verify the actual legal status of the neonate (liveborn or stillborn) before removal of the body to insure legal documentation of the event.
- Hospice R.N.s may only pronounce death under conditions specified in Wis. Stat. s. 69.18(1)(cm). For anticipated deaths of enrolled hospice patients.
- Each Coroner/M.E. has county-specific written policies on reporting deaths. Reporting nonhospital/nursing home deaths (including deaths under hospice care) may still be mandatory [Wis. Stats. ss.979.01, 979.10, and 69.18(2), and/or DHS Administrative Rule 135.08].

DEPARTMENT OF HEALTH SERVICES
Division of Public Health
(Rev 09/13)

PART 2

STATE OF WISCONSIN
Chapter 69, Wis. Stats.
Page 3 of 3

NOTICE OF REMOVAL OF A HUMAN CORPSE FROM A FACILITY

Communicable Diseases Reportable to Personnel Involved in Postmortem Activites

(Confidential Information Available Only to the Funeral Director or Person Acting as Such)

DO NOT TRANSMIT THIS PORTION OF THE NOTICE OF REMOVAL TO THE LOCAL VITAL RECORDS OFFICE.

1. DECEDENT'S CURRENT LEGAL NAME- First	Middle	Last	Suffix
AKA:			

2. SEX	3. AGE AT DEATH ☐ Years ☐ Months ☐ Days ☐ Hours ☐ Minutes ☐ Stillbirth	4. DATE PRONOUNCED DEAD	5. TIME PRONOUNCED DEAD (0000-2359)

6. FACILITY NAME	7. FACILITY MAILING ADDRESS

*Per Wisconsin Statute ss. 69.18(3)g and 252.15 (3m)(d)7 and DHS Administrative Rule 135.04(3), a hospital, nursing home, or hospice **must** provide information concerning certain existing communicable diseases to the funeral director, the person acting as funeral director, the Coroner/M.E., or the representative of the Coroner/M.E. at the time the body is removed. See important notes below. Both 8 and 9 below must be*

8. To the best of my know ledge and belief, the above-named decedent's medical record documents the presence of the follow ing communicable disease (s) suspected or confirmed for this person:

- ☐ Clostridium Difficile
- ☐ HIV (Positive Results) (Available only to funeral directors per s.252.15(5), Wis. Stats.)
- ☐ Other serious blood-borne transmittable disease (e.g., Hepatitis)
- ☐ Methicillin-Resistant Staphylococcal Aureus (MRSA)
- ☐ Plague
- ☐ Prion diseases (such as CJD)
- ☐ Rabies (human)
- ☐ SARS
- ☐ Smallpox and other orthopox diseases
- ☐ Staph
- ☐ Tuberculosis
- ☐ Tularemia
- ☐ VancomycinResistant Staphylococcal Aureus (VRSA)
- ☐ Varicella
- ☐ Viral hemorrhagic fevers

☐ The designee completing this report examined the patient's active medical record but did not find any of the above-mentioned conditions documented in the active medical record available to him or her at the time of release of the body.

☐ The decedent died in the ER or was DOA and there was no historical medical record at the facility at the time of release of the body.

9. NAME OF STAFF PERSON COMPLETING PART 2 (must be a person who can reasonably attest to the above statements)

10. **SIGNATURE** - STAFF PERSON COMPLETING PART 2	11. DATE SIGNED	12. PHONE NUMBER

IMPORTANT NOTES

- Per Wisconsin Statute section 69.18 (3)g, it is the legal responsibility of the health care facility or hospice agency to provide the funeral director, or person acting as such, with information about any known dangerous communicable diseases documents in the decedent's medical record.
- It is understood that, in some cases, diseases may be present but undiagnosed or the facility may not be aware of a prior diagnosis that is not documented in the medical records available to the medical facility.
- Funeral directors, or persons acting as such, and Coroners/M.E.s and their representatives must use universal precautions when handling <u>all</u> bodies to prevent the transmission of bloodborne pathogens and to be in compliance with OSHA standards.

CREDITS

Storyline developed in collaboration with Carol Ness, APNP, palliative care specialty

Advance directives document available from the Wisconsin Medical Society, "Honoring Choices Wisconsin." Retrieved from: https://www.wisconsinmedicalsociety.org/professional/hcw/

End of Life learning objectives from: Peaceful Death: Recommended Competencies and Curricular Guidelines for End of Life Nursing Care, End of Life Nursing Education Consortium. Retrieved from: http://www.aacn.nche.edu/elnec/publications/peaceful-death

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Wisconsin Department of Health Services. Notice of Removal of Human Corpse form. Retrieved from: https://www.dhs.wisconsin.gov/library/F-05043.htm

Wisconsin Department of Health Services. Patient Death Determination form. Retrieved from: https://www.dhs.wisconsin.gov/regulations/report-death/proc-reportingdeath.htm

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