I. **PURPOSE**
To ensure the coordination of respectful care of a body following the pronouncement of death in all care units at Regions Hospital and HealthPartners Same Day Surgery Center (HPSC). In addition, this policy is designed to meet state and federal regulations as well as Joint Commission standards in regards to the communication, referral, consent, management, and procurement of organ, tissue, and eye donations.

II. **POLICY**
A. When a death occurs on the Regions Hospital or HealthPartners Specialty Center, in order to assist and support the patient’s family in a time of grief and loss.
   1. The family and / or significant other(s) will be notified as quickly as possible.
   2. All personnel will demonstrate respectful communication, actions, and behaviors through the final disposition of the body.

B. As necessary, the appropriate legal authorities will be notified. The Patient Flow Coordinator (PFC) will assist in the coordination of after care for the body. The attending physician or designee will complete the patient’s electronic health record (EHR) and death certificate within a timely fashion. The official record of deaths for Regions Hospital will be based on the PFC’s death log, supported by Epic documentation.

C. All patient deaths, 20 weeks gestation and older, will be referred for organ, tissue, and eye donation assessment. As per guidelines the LifeSource Coordinator (LC) will evaluate and recommend suitability for donation.

D. When the patient is a potential organ donor and the legal next of kin authorizes the donation or written donor designation exists, the LC will complete the written informed authorization.
E. A fatally ill patient who has total irreversible loss of brain function resulting in the diagnosis of brain death is potentially a suitable candidate for solid organ donation (e.g., kidney, heart, lung, liver, small bowel, pancreas) and the donation of tissues (e.g., eyes, bone, skin, connective tissue, heart for valves, arteries / veins).

F. Individuals with complete and permanent cardiac and respiratory cessation may be potential suitable candidates for tissue donations, (e.g., eyes, bone, skin, connective tissue, heart for valves, arteries / veins).

G. Twice daily Pathology will reconcile and document the morgue log to the deceased in refrigerated crypt / cooler storage.

H. All access to the morgue will be managed and coordinated through Regions Hospital Security and The Department of Anatomic Pathology.

I. Morgue access will be restricted to approved personnel with documentation of all persons entering the morgue who are not members of Pathology or Security staff.

J. Quality assurance will be managed by monthly audits as per Morgue Procedure Fetal Loss / Stillbirth RH-PC-PL-MO-6.3.1.

III. PROCEDURE(S)
A. Prior to or Impending Patient Death
   1. The Licensed Independent Providers (LIP) and nurses responsible for the care of the patient will refer all patients with imminent brain death, cardiac or respiratory cessation for donation evaluation within one hour of meeting the following triggers:
      a. Severe neurological injury
         i. Glasgow Coma Scale (GCS) less than 5 or the patient must demonstrate complete absence of two or more of the following:
            • Response to pain
            • Trigger of ventilator
            • Pupillary response
            • Corneal reflex
            • Cough
            • Gag
            • Doll’s Eyes
            • Response to cold caloric’s
      b. All questions about donation from family or staff will be referred to Organ Donation staff.

B. Death of a Patient Flow Chart
Patient Death Flowchart

Death in OR  Death in ER  Inpatient Death  Death in clinic or procedural area.

Care Units page PFC at 651-629-2002

PFC works with Care Unit to notify and complete:
- Lifesource & Lions Eye Bank organ and tissue donation
- Family
- Attending or on call Physicians
- Chaplain on-call is available to support the family
- ME - if needed. Preserve site.
- Post Mortem Permit - if need. Preserve site.
- Ensures family views the body
- Post Mortem Consultation From - if needed.
- Property Card
- Epic Death Checklist
- PFC provides funeral home with attending physician or designee name for completion of Death certificate

Transport body to morgue

Care Unit faxes Death checklist to PFC @ 651-254-3643

PFC, PA* and Security see Flowchart next page

Autopsy and/or Organ & Tissue donation

PFC notifies security and the funeral home that body is ready for release

Funeral Home: 1. Notifies Security to arrange pick-up time; 2. Originates death certificate

PFC completes:
- Death checklist, review and update as needed, faxes final copy to 651-254-2741

*PA - Pathology Assistant

See page 5 for Family Perspective Flowchart
Patient Death Flowchart (page 2)

- PFC, PA* and Security Entry from main flowchart

**Autopsy only**

- PFC calls autopsy pager (651-629-0169)
- PA* verifies:
  - Death checklist
  - Postmortem consult form
  - Autopsy permit
- PA* notifies PFC when autopsy complete

**Autopsy and/or Organ & Tissue donation**

- Donation only

  - Lifesource contacts PFC
  - Lifesource works with OR

- PFC contact Security
  - Lifesource arrives, Security releases body
  - Lifesource notifies PFC when complete

- Body returned to morgue

**YES, both**

- PFC coordinates both procedures with the PA* through autopsy pager (651-629-0169)
- PA* verifies paperwork (death checklist, postmortem consult form, autopsy permit)
- PFC contacts Lifesource & OR to schedule donation

- PA* notifies PFC when autopsy complete

*Lifesource arranges for donation*

*PA - Pathology Assistant*
C. Determination of Death

1. Brain Death
   b. Patients diagnosed with “Brain Death with intact cardiovascular system” are suitable candidates for organ, tissue, and eye donation.
   c. Physicians / Nurses responsible for the patient's care, or designee, will refer all patient deaths (patients with imminent brain death or cardiac and respiratory cessation) within one hour of meeting clinical triggers (the loss of two (2) or more brain stem reflexes or a GCS of less than or equal to 5 in the emergency department [ED]) for donation evaluation by calling the donor referral number at 1-800-247-4273. Imminent brain death is defined as the loss of 2 or more brain stem reflexes. Do not discuss donation with the family prior to making the referral.

2. Cardiac Death
   a. Individuals with complete cardiac and respiratory cessation are not suitable for organ donation but may be suitable for tissue donation (e.g., eyes, bone, skin, connective tissue, heart for valves, arteries / veins).
   b. Physicians and / or nurses responsible for the patient's care, or designee, will refer all patient deaths (cardiac and respiratory cessation) for donation evaluation as soon as possible after asystole by calling the donor referral number at 1-800-247-4273. Do not discuss donation with the family prior to making the referral.

D. Pronouncement of Death

1. For all deaths, the death of a patient policy and procedure should be followed in all areas of the Regions Hospital regardless of the location in which the patient died (e.g., ED, Surgical Services, and clinics).
2. The Resident or nurse in the case of a Do Not Attempt Resuscitation (DNAR) patient may pronounce the death of a patient. The attending physician on the primary service responsible for the patient must be notified if the resident or nurse makes the pronouncement of death. Documentation is the same for all deaths.
   a. Nursing documentation regarding the death must include:
      i. Attending (on call) MD notification and time of MD notification.
      ii. Document patient’s condition prior to death and emergency measures attempted.
      iii. Evaluation statement “Emergency measures unsuccessful and patient expired at (include date and time of death).”
   b. See Section D regarding additional nursing responsibilities

3. Deaths occurring in Special Care Areas (e.g., Cath Lab, Dialysis, Imaging, HPSC)
   b. Secure patient belongings.
      i. Return belongings to the family; or
      ii. Place in safe located in the Business Office.
   c. Complete property card and keep with body.
   d. PFC will direct body viewing, transport, family and physician notification, and documentation.

4. Fetal / Neonatal Deaths
   a. For Fetal Death (see definition of Fetal Death in Section IV)
      i. The patient’s nurse or charge nurse of non Birth Center units must consult with the Labor & Delivery (L&D) charge nurse regarding requirements for care of the stillborn (651-254-3405).
      ii. Refer to Fetal / Neonatal Loss Policy (RH-PC-BC-02-10) and Procedure as outlined in the Birth Center Manual.


E. Nursing Responsibilities

1. Notifications
   a. The attending (on call) MD must be notified. Note: This can be a joint responsibility with the resident.
   b. The Medical Examiner (ME) is notified, if applicable. For further instruction see Section D
   c. The physician or nurse notifies the family regarding the patient’s death.
      i. If the family is present, the physician will talk with the family in private. Nursing is encouraged to be present during this discussion to reinforce what has been said and answer questions.
      ii. If the family is not present, the physician / nurse is to call and ask them to come to the hospital.
      iii. If the physician is unable to contact the family, he / she will notify the nursing staff. If necessary, the Director of Nursing / PFC can be used as a resource in contacting the family.
      iv. If the decedent is a resident of a nursing home or other care facility, nursing or family will contact the facility. If no family is present, this notification will be done by the responsible nurse.
      v. If the patient is incarcerated, the responsible nurse will notify the Watch Supervisor. The Watch Supervisor will notify the Warden or Superintendent of the home institution. The home institution will provide direction on family notification.
      vi. Provide family with any bereavement materials as applicable.
      vii. The physician or responsible nurse discusses the needed decisions of postmortem, ME possibilities, Selection of Mortuary, and Donations.
d. The PFC is notified of all deaths (651-629-2002) and a hold is placed on the body until the EHR death checklist is completed.

e. As needed, the PFC will assist the care unit in coordinating the following:
   i. Pending decisions regarding donation or autopsy.
   ii. Transportation of deceased patient to the morgue.

f. Chaplain-Chaplaincy services are available as needed or requested. Contact the on-call chaplain through Amion or the hospital operator.

g. Epic: Complete Epic documentation using the Death Navigator in the EHR
   i. Complete Epic Death Checklist in the EHR.
      - The care unit faxes the completed Death Checklist in the EHR to PFC at 651-254-3643.
   ii. Complete patient discharge:
      - Location: Morgue.
      - Disposition: Expired.
   iii. Enter “expired” status in Epic to update patient status.

h. Completion of Property Card (See Section D).

2. Transfer of the Body / Property

   Note: If the body requires special needs (e.g., Bariatric patients) contact PFC for direction prior to transport.

   a. Transfer of the body to the morgue will take place as soon as possible after the death. The PFC should be notified if the transfer is not possible within a timely fashion. One reason for this exception may be family wishes to view the body on the unit. See Exception listed in Section F.

   b. Contact Patient Transport for patient transfer assistance as needed.

   c. Contact Security (651-254-3979) for morgue access prior to beginning transport.

   d. A nurse (RN / LPN) must accompany the patient to the morgue.

   e. If needed, Patient Transport may assist with the physical relocation of the patient’s body but must be accompanied by nursing and escorted by security into the morgue. Upon arrival to morgue Security will escort the care team into the morgue.

   f. The nurse and Security will sign the patient into the morgue log the following information must be complete:
      i. Date.
      ii. Deceased’s Name, Age, Care Unit.
      iii. Refrigerated Storage placement.
      iv. Time in morgue.
      v. Nurse and Security / Pathology signature.
      vi. Paper Chart (yes or no) accompanied the body.
      vii. Autopsy (yes, no, or pending).
      viii. Autopsy date / time (to be completed by Pathology).
      ix. Donor services (yes, no, or pending).
      x. Donation date and time – Out (to be completed by Procurement Team).
      xi. Donation date and time – In (to be completed by Procurement Team).

   g. The care team will transfer the body to the designated morgue cooler cart.

   h. In addition to the body, all personal belongings will be placed onto the cart with the patient’s body.

   i. The accompanying nurse will complete the morgue log entry to include cart ID.

   j. The nurse will complete the blue envelope located in the morgue and will place the patient’s hard copy paper chart into the blue envelope. Minimally, the patient chart must include the following:
      i. EHR Death Checklist.
      ii. Post-Mortem Permit (if applicable).

   k. All individuals will exit the morgue together. Security must accompany and remain with staff at all times while conducting business in the morgue.

   l. Security will ensure the morgue is secure upon exit.
m. Deceased remains in morgue cooler until released to the authorized funeral home, crematorium, or medical examiner who will take custody of the body.

n. Security will ensure the authorized party removing the body from the morgue will complete the morgue log.
   i. Mortuary, address, license #, Mortuary signature, date and time.
   ii. Security release initials.
   iii. Chart pick-up date, time, and initials (completed by Pathology).

o. The licensed funeral home or crematorium will provide a certificate of removal upon arrival.

p. If the family or medical examiner requests the body to be removed from the patient care unit, the nurse will accompany the ME or Funeral Home Director to the morgue and all steps contained in The Death of a Patient and Organ Donation Policy Procedure D.2.

q. All individuals who enter the morgue must be authorized and accompanied by security at all times.

3. Family and visitors will not be authorized to enter the morgue at anytime. Please see Attachment B if family request to view the patient’s body after the body was signed into the morgue – follow process on The Death of a Patient and Organ Donation Policy: Attachment B.

4. Reportable Cases to the ME: Deaths which occur at Regions Hospital and meet the criteria below are reportable regardless of where the injury occurred.
   a. Criteria for Reporting Death(s) to the ME (Reportable Deaths).
      i. Death within first 24 hours of hospital admission.
      ii. Any death in which there is doubt as to whether it constitutes a medical examiner's case.
      iii. Deaths due to violent homicide, suicide or accident (e.g., all trauma).
      iv. Deaths associated with burns, chemicals, electrical, thermal or radiation injury.
      v. All maternal deaths due to criminal abortion or miscarriage.
      vi. Deaths under unusual or mysterious circumstances.
      vii. Deaths that occur during, in association with, or as the result of a diagnostic, therapeutic or anesthetic procedure.
      viii. Deaths of inmates of public institutions, not hospitalized primarily for organic disease.
      ix. Deaths of persons in custody of law enforcement officers.
      x. Any death due to suspected neglect or abuse.
      xi. Any stillbirth ≥ 20 weeks gestation.
      xii. A pregnancy of any gestation that results in stillbirth or neonatal death because of trauma of any kind, positive toxicology screening, maternal ingestion of an unprescribed controlled substance, or illicit drug use.
      xiii. Any death in the ED.
      xiv. All sudden deaths of persons not disabled by recognizable disease.
      xv. All deaths in which a fracture of a major bone (femur, humerus, tibia, etc.) has occurred within the past six months.
      xvi. Death of a person whose body is to be cremated, dissected, buried at sea, or otherwise disposed of so that bodies will later be unavailable for examination.
   b. Reporting and Documenting Cases to the ME.
      i. Report the case promptly to the office of the ME (651-266-1700).
      ii. The office is open 24 hours daily. The physician / responsible nurse / procurement agency RN may make this call. The charge nurse will ensure that this reporting has been done.
      iii. Information requested by the ME will include patient name, address, sex, race, marital status, next of kin, summary of history, physical findings, name of attending physician and other pertinent data.
      iv. Documentation of this notification will be done on the EHR Death Checklist.
v. When notifying the ME office, the wishes of the family regarding postmortem exam should be conveyed. If the ME does the postmortem examination, a signed postmortem permit is not needed. A ME has jurisdiction to perform the postmortem exam regardless of family permission. In the case of the ME declining the need for their office to perform postmortem exam, a postmortem examination can be done by the hospital if permission has been obtained from the ME and family (See Section D, to obtain the family’s permission).

vi. The ME will make a judgment as to whether they accept or decline jurisdiction. This decision will be done immediately at the time of the original contact with the ME’s investigator or will be conveyed to the Regions PFC by the next working day. Until jurisdiction is decided the decedent’s body is on hold and is to not be altered.

a. ME accepts jurisdiction.
   i. The ME will state that the case is under the jurisdiction of the Office of the Medical Examiner.
   ii. The death certificate is signed only by the ME in cases where the ME has accepted jurisdiction.
   iii. The removal of clothing or effects, handling of the body, altering the scene, or the completion of a postmortem examination (except by specific authorization of the medical examiner, his deputies or investigators) should not occur. All clothing and belongings should be sent with the body to the ME. Clothing and other personal belongings may assist the ME in their investigation of the death. If the relevancy of belongings for the investigation is questioned, verify with the ME their need for these articles. Do not send valuables already locked in the Business Office.
   iv. Next of kin should be directed to contact the Office of the Medical Examiner (651-266-1700) for concerns regarding circumstances of death, cause of death, and concerns about personal effects. In many instances the ME personnel will be contacting the family for information, which may be helpful in the case.

v. The family should be informed to contact their Funeral Home / Mortuary.

b. ME declines jurisdiction.
   i. The ME will authorize release of the body to the Funeral Home / Mortuary.
   ii. The procedures for autopsy / postmortem care of the body / property should be followed as if the case was a non-reportable death.
   iii. The family / next of kin should be contacted about considering a Regions Hospital postmortem exam.
   iv. The family should be informed to contact their Funeral Home / Mortuary.

5. Family Decisions
   a. Postmortem Examinations
      i. Postmortem examinations are performed at no cost to the family provided the death occurs at Regions Hospital.
      ii. Permission should be sought from the family / next of kin for a postmortem examination for all patients. Responsibility for obtaining this permission belongs to the physician and / or responsible nurse who conveys the announcement of death to the family. If the family consents to a postmortem, the permit form (See Section H) should be completed (even prior to contact with the ME).
      iii. Reinforce with the family that if the ME requires the postmortem, it will be done regardless of the family giving permission.
      iv. The next of kin who has the legal authority, via MN state law 149A.80, to give permission for the postmortem examination are identified below in the accepted legal order. Legal order must be followed in obtaining consent for a postmortem examination.
• The person appointed in a dated written instrument signed by the
decedent (does not include durable and nondurable power of attorney)
• The surviving, legally recognized spouse.
• The surviving biological or adopted child or children of the decedent over
the age of majority, see note below.
• The surviving parent or parents of the decedent.
• The surviving biological or adopted siblings of the decedent over the age
of majority, see note below.
• The person or persons respectively in the next degree of kinship in the
order named bylaw to inherit the estate of the decedent.
• The appropriate public or court authority.

Note: You can rely on instructions given by the surviving child that they are the
sole surviving child, or if there are multiple children, that they constitute a
majority of the surviving children. You can rely on instructions given by the
surviving sibling that they are the sole surviving sibling or if there are multiple
siblings that they constitute a majority of the surviving siblings.

v. Physician / responsible nurse completes Section I of the Postmortem Permit
and signs as a witness, if needed.

vi. Next of kin giving permission for the postmortem exam completes Section II of
Postmortem Permit.

• As many signatures as can be easily obtained are recommended.
• When the next of kin resides a substantial distance from the hospital or
the next of kin is not able to sign the postmortem permit in person
telephone permission for the postmortem exam is acceptable with one (1)
woman i.e., three way phone call. If permission is obtained via the
telephone this must be documented on Section II of the post mortem
permit by the witness.

vii. The PFC pages the Pathologist Assistant at (651-629-0169) to notify the need
for a postmortem exam.

viii. The Physician must then complete the Postmortem Consultation Form (See
Section H). The completed form should go with the body and chart to the
morgue.

ix. The Pathology Department facilitates completion of the postmortem
examination.

x. Preliminary postmortem results are available 72 hours from autopsy.

xi. Final postmortem results are available no later than 60 days from autopsy.

xii. The postmortem report is given only to
• The person(s) who signed the postmortem permit
• The primary care provider identified in the EHR

xiii. Physician who completes the death certificate answers questions from family
on postmortem results.

b. Selection of a Funeral Home / Mortuary
i. Request the family select a Funeral Home / Mortuary
ii. Inform the family they are responsible for notifying the Funeral Home /
Mortuary themselves

6. Organ, Tissue & Eye Donation – Note: LifeSource, The Upper Midwest Organ
Procurement Organization, Inc. is the official procurement agency for Regions Hospital for
organs and effective December 29, 2004 for tissues. The Minnesota Lions Eye Bank
(MLEB) is used for eye donations.

1. The nurse calls Donor Referral #1-800-247-4273 if the patient is > 20 weeks
gestation. Verify if patient meets criteria for organ / tissue / eye donation. Do not
discuss donation with the family prior to making the referral.

2. Brain Death – Organs, tissues and eyes. Note: Refer all patient deaths (patients with
imminent brain death or cardiac and respiratory cessation) within one hour of
meeting clinical triggers (the loss of two [2] or more brain stem reflexes or have a Glasgow Coma Scale (GCS) of less than or equal to 5 in the ED).

i. Suitability for Donation

- The contracted LC will determine if the patient meets criteria for organ, tissue, and / or eye donation after discussion with the physician / nurse, and / or evaluation of the medical record.
- After brain death declaration, if suitable for organ donation, a LC will be on-site to offer the next of kin the option of donation or discuss the patient’s donor designation in collaboration with the patient’s physician, nurse, and other members of the healthcare team as appropriate.
- If suitable for tissue / eye donation but not organ donation, the tissue / eye coordinator will discuss either the option of donation or donor designation with the family via the telephone using the assisted approach (family connection) after the patient’s death.
- Families of patients who do not meet donation criteria, per the LC, will be told by the physician / nurse responsible for the patient’s care, or designee, that normally donation is discussed at this time, however, because of a contraindication defined by LC donation is not an option.

3. Cardiac Death – Tissue and Eye Donation Only. Note: Individuals with complete cardiac and respiratory cessation may be suitable candidates for tissue or eye donation (e.g., eye, bones, skin, connective tissue, heart for valves, arteries / veins). Referrals should be done as soon as possible after asystole.

i. Suitability for Donation

- The LC will determine if the patient meets criteria for tissue and / or eye donation after discussion with the physician / nurse, and / or evaluation of the medical record.
- If suitable for tissue / eye donation, the LC will discuss either the option of donation or donor designation with the family via the telephone using the family connection.
- Once the determination of suitability is made, the nurse will be asked to offer the family the brochure, Tissue & Eye Donation. At this point, tell the family that it has been determined that their loved one could be a donor (the LC will be able to tell you whether or not your patient is a documented donor and how to relay this information to the family). Inform the family that a LC will speak with them now or will contact them later. If the family chooses to leave the hospital prior to speaking with a LC, obtain a telephone number where they can be reached.
- The LC will talk with the family via the telephone (at the hospital or at their home) and complete all necessary documentation.
- The LC will inform the PFC of the family’s decision, and a copy of the authorization / disclosure form will be provided to medical records.
- Families of decedents who do not meet donation criteria, per the LC, should not be approached for donation. The nurse responsible for the patient’s care, or designee, will tell families of these patients, that normally donation is discussed at this time; however, because of a contraindication defined by the LC donation is not an option. The medical contraindication given by the LC should be recorded on the Record of Death; Screening for Organs, Tissues & Eyes form. This form is provided by the LC.
- If suitable for eye donation only, the MLEB Donation Coordinator will offer the family the option of donation via the telephone using the family connection.

4. Use of Interpreters – When appropriate, due to cultural diversity, the Interpreter / Language Services should be contacted to interpret the discussion. The person
reviewing this issue will document the discussion on the patient’s record. Such contact shall occur with due discretion and sensitivity regarding the circumstances, views and beliefs of the family.

5. Donor coordinators will make the final determination of a donor’s suitability for which organs and tissues may be donated and will coordinate the organ, tissue, and eye retrieval with Regions Hospital and local / national transplant centers. If suitable for eye donation only, the MLEB Donation Coordinator will offer the family the option of donation via the telephone using assisted approach (family connection).

6. Determination of Donor Designation
   i. If donation is an option, the LifeSource Coordinator will lead the donor designation assessment for patients documented intent or refusal to donate. If Advanced Directives are noted on the chart, inform the Donation Coordinator of any patient’s decision about donation. Do not ask the family for the information. Regardless of designation or not, discuss method of approach with Donation Coordinator
   ii. ME: If the donor is subject to the ME’s jurisdiction and is a possible organ / tissue / eye donor, the ME is called at the time of the first brain death determination. The ME, or their designee, may then decide to externally examine the patient to obtain necessary medical / legal evidence or to decide to release the body for organ / tissue / eye donation. The external examination may include taking pictures. After the exam, the ME will document in the EHR the decision as to the release of the body for organ donation. If the ME is releasing the body for organ / tissue / eye donation, they will grant a telephone authorization for this procedure. The ME’s name, date and time of this telephone authorization to release the body, and if they will want to do an external examination, needs to be documented in the EHR.

7. Management of the donation of a body remains to the University of Minnesota (U of MN).
   a. If any patient or family member is interested in donating their body to the U of MN, they should call 612-625-1111. U of MN Anatomy Bequest Program to obtain the correct procedure for donation to the U of MN Anatomy Bequest Program
   b. The patient / family has presented or informed medical staff of the presence of an Anatomy Bequest Form. A copy of the most up-to-date form may be found at http://www.bequest.umn.edu/
   c. The Anatomy Bequest Program phone number is 612-625-1111 (24 hour service). They will be contacted by the LIP at the time of the patient’s death.
   d. Further procedure upon donation will be discussed between LIP and U of MN Anatomy Bequest Program.

8. Organ Procurement Procedure:
   a. After brain death and family authorization or disclosure, LC will remain on-site to clinically manage the patient, allocate the organs, and coordinate the organ recovery. Organ procurement is performed in the Regions Hospital operating room. The following forms will be sent with the body:
      i. Complete Death Checklist in the EHR Authorization or Disclosure for Organ, Tissue and Eye Donation. No other surgical consent form is necessary.
      ii. Completed postmortem examination permit, if a postmortem or equivalent examination is requested. A permit is not necessary if the ME assumes jurisdiction for the case.
      iii. Patient records – A copy of the patient’s current medical record, including flow sheets and laboratory results. The Donation Coordinator will identify the specific portions of the chart to be copied. This data is given to the team(s) who will procure the organs.
      iv. The patient’s previous medical record.
   b. Upon determination of a patient death, it is the responsibility of the care team to page the PFC (651-629-2002).
c. When the organ donation procedure is complete, the body will be transferred and signed into the morgue per the Regions Hospital Death of a Patient and Organ Donation follow Policy Procedure D.2.
d. An operative report will be provided by the donation team.

9. Tissue Procurement Procedure:
   a. After brain or cardiac death and family authorization / disclosure, LC will coordinate tissue recovery with the PFC.
      i. Complete Death Checklist in the EHR Authorization or Disclosure for Organ, Tissue and Eye Donation. No other surgical consent form is necessary.
      ii. Completed postmortem examination permit, if a postmortem or equivalent examination is requested. A permit is not necessary if the ME assumes jurisdiction for the case.
      iii. Patient records – A copy of the patient’s current medical record, including flow sheets and laboratory results. The LC will identify the specific portions of the chart to be copied. This data is given to the team(s) who will procure the organs.
      iv. The patient’s previous medical record.
   b. Tissue procurement is performed in the Regions Hospital operating room. Room availability will be coordinated between the PFC and Operating Room Charge Nurse.
   c. The Tissue Coordinator will provide a copy of the authorization / disclosure for donation form along with documentation of which tissues were recovered for the patient chart.
   d. When the tissue donation procedure is complete, the body will be transferred and signed into the morgue per the Regions Hospital Death of a Patient Policy Procedure D.2 Procured tissue will be packaged and held in the Regions Hospital Pathology Laboratory for courier retrieval.

10. Eye Procurement Procedure:
    a. The MLEB coordinates eye donation and transplantation. The MLEB Certified Procurement Technicians remove the whole eyes or corneas only, determined by the LC, for corneal donation. Eye enucleation / insitu recovery can be performed in the OR, on the patient care unit, in the morgue, at the Funeral Home / Mortuary, or at the ME’s office.
    b. All potential eye donors should be treated using the following post-mortem care:
       • Elevate head 10-20 degrees.
       • Vertically paper tape eyes closed, when possible. Closing eyes as soon as possible is also important.
       • Place light ice bags gently over taped, closed eyes before body is sent to the morgue.
    c. Notify the PFC when procurement procedures are completed.
    d. The patient's chart is sent with the body.
    e. All nursing documentation in the progress notes follows the same procedure as any other death.

11. Care of the Body / Property and Viewing by Family:
    a. Care after death / viewing by family – The purpose of caring for the body is to ensure cleanliness before taking it to the morgue and to ensure proper disposition of belongings.
       i. Obtain the morgue cart by calling Materials Management x49588 or ordering it via EHR.
       ii. Obtain a Morgue Pack from Materials Management or via EHR.
       iii. Proceed with postmortem care after the patient has been pronounced dead and the relatives have left the room.
       iv. Do not remove tubes, clamps, splints, casts, etc., if there is to be a possibility of a postmortem or if it is a ME reportable case. Do not wash the body.
       v. Close eyes. If the eyes do not remain closed, paper tape may be used. If eyes
are to be donated, vertically tape eyes shut and place small ice packs on eyes. Elevate the head of the bed 20°.

vi. In deaths due to violence, suspected homicide or suicide or if pending ME jurisdiction do not bathe the body. If chain of evidence is needed on ME or Pending ME case do the following:

- Never leave evidence unattended.
- Obtain a Chain of Evidence Form (See Section H).
- Complete Chain of Evidence Form following the instructions on the form.
- Use paper bags (not plastic) for personal items such as; clothing, personal belongings, place jewelry inside a blue specimen cup and seal prior to placing in paper bag.
- Secure all packages with evidence tape available from Security.
- Label the outside of the paper bag with the patient’s name, “A” number, and the contents placed inside the bag. The contents in the bag should also be recorded on the Chain of Evidence Form.
- Make copies as designated.
- Evidence can only be released to the proper authorities and must be recorded on the Chain of Evidence Form.
- Call Security 651-254-3979 to secure evidence.

vii. If the patient was in isolation at the time of death, maintain the isolation procedure while preparing the body for the morgue.

eviii. Complete death tags (2 for body, 1 for the morgue identification card plus the number needed for labeling belongings).

ix. Leave identiband on patient.

x. Replace dressings with fresh ones.

xi. If the false teeth are in the mouth, leave them there. If false teeth are not in the mouth, place them into a denture cup and place in shroud with body.

xii. If hair has been cut, contain and place in shroud with body.

xiii. Remove any narcotic patches from the deceased before transporting the body to the morgue. Discard according to policy for wasting narcotic patches.

xiv. Place one death tag around the ankle.

xv. Place body face up. Adjust defecation pad under buttocks and wrap the body diagonally in a morgue sheet, leaving arms loose at sides. Note: If family is yet to view the body, place one arm outside of sheet. Once family has left:

- Tape the morgue sheet securely, particularly around the sides of the head and neck.
- Tape one death tag on the morgue sheet at the chest.

xvi. The Universal Precautions Tag will be placed on the ankle tag.

xvii. Once the body is securely placed and positioned within the body bag, the body bag is closed and an EHR generated patient label is placed on the exterior of the bag to support positive patient identification and transfer to the morgue.

b. Care of property / body.

i. Disposition of all items should be identified and documented on the Property Card (See Section H).

ii. All belongings including valuables should be given to relatives. If relatives are not present:

- Rings, necklaces and other valuables are to be sent to the Business Office.
- Glasses, dentures, prosthesis, clothing and any other items, which cannot be removed are sent to the morgue with the body.

iii. Personal items / valuables may have been removed prior to death and submitted to police using chain of evidence procedure. Documentation of these
items can be found on the Chain of Evidence Form (See Section H). Check on the Property Card that a chain of evidence form was used.

F. Attending Physician Responsibilities

1. Notifications
   a. Family – See joint Nursing Responsibilities Section D.
   b. PFC (if applicable) – If you are unable (i.e., off service) to complete the patient’s death certificate immediately inform the PFC of your designee at pager 651-629-2002.
   c. The primary physician and / or referring physician, if applicable.

2. If applicable, the last attending physician may be contacted by the ME (on all reportable deaths) inquiring information about past medical history of the decedent, the most likely cause of death, and the relationship of any physical or chemical injury.

3. If applicable, complete the post mortem consultation form for all autopsy requests performed at Regions Hospital.

4. Chart completion – Although most charting is done in Epic, the remaining paper documents will be made available to the Health Information Management (HIM) department 24 hours after the patient’s death.

5. Death Certificate Completion – Non-ED (Death Certificates should be completed within 48 hours of receipt of request if at all possible).
   a. The PFC will provide the family’s designated Funeral Home / Mortuary with the name of the attending physician or their designee
   b. The designated Funeral Home / Mortuary will originate all death certificates by contacting the designated physician or clerical assistant through email.
   c. Complete death certificate using the State of Minnesota online reporting system MN VRV2000. Note: a user id is required.

6. Death Certificate Completion – ED (Note: All cases are reported to the ME)
   a. If the ME accepts jurisdiction the ME will complete the Death Certificate.
   b. If the ME denies jurisdiction the Primary Medical Physician will complete the Death Certificate.
   c. If the Primary Medical Physician refuses to complete the Death Certificate, the ME will assume the responsibility of Death Certificate completion.
   d. If there is no Primary Medical Physician available, the ME will complete the Death Certificate.
   e. Consultation and / or answering questions for the family about the circumstances leading to the death will be done by the ED physician.
   f. Funeral homes will be instructed by the PFC’s to seek the Primary Medical Physician, or to contact the ME.

7. Consultation and / or answering questions for the family about the cause of death or postmortem results will be done by the physician who signs the death certificate.

G. Release of the Body

1. PFC responsibilities:
   a. Verify the completeness of the EHR Death Checklist.
   b. Communicate with security and / or the authorized Funeral Home / Mortuary to obtain appropriate authorization to release the body. State law prohibits families to transport a body out of the hospital unaccompanied by a licensed Funeral Home or Mortuary.

IV. DEFINITIONS

1. Fetal Death – death before the complete expulsion or extraction from the mother of a product of human conception, fetus and placenta, irrespective of the duration of pregnancy; the death is indicated by the fact that, after such expulsion or extraction, the fetus does not breathe or show any other evidence of life, such as a beating heart, pulsation of the umbilical cord, or the definite
movement of voluntary muscles. Heartbeats are to be distinguished from transient cardiac contractions; respirations are to be distinguished from fleeting respiratory efforts or gasps. This definition excludes induced termination of pregnancy.

2. **Neonatal Death** – death of a live-born neonate before the neonate becomes age 28 days (up to and including 27 days, 23 hours, and 59 minutes from the moment of birth).

3. **Family** – defined as family, significant other, or close personal friend / Responsible Parties

V. **COMPLIANCE**

Failure to comply with this policy or the procedures may result in disciplinary action.

VI. **ATTACHMENTS**

Attachment A – Summary of Forms and Documentation
Attachment B – Process for Family Request to View Patient’s Body Post-Discharge to Morgue

VII. **OTHER RESOURCES**

*Internal*
- PC-02-15 Criteria for Determination of Death by Physicians
- PC-02-20 Donation After Cardiac Death
- PC-10-27 Principles and Guidelines for Limiting Treatments
- BC-02-10 Infant Loss – Nursing Interventions (Birth Center Manual)
- Emergency Medicine Administrative policies, A-N, Death and DOA section, page 7

VIII. **APPROVAL(S)**

Chris Boese, RN, MS, NE-BC  
Vice President Patient Care Services

IX. **ENDORSEMENT**

- Infection Control: August 2015
- Quality, Patient and Education Council: June 2015
- Patient Care Committee: August 2015