21. Death Reporting

ORR Death Review form
Death Reporting Guidelines
LARA Death Reporting form
CMS report of hospital death associated with restraint or seclusion (LPH only)
CMH Contract Requirement for Death Reporting

OFFICE OF RECIPIENT RIGHTS
REVIEW OF DEATH

Recipient's Name:

Date of Death:

The following items were reviewed:

- ☐ Report of Death (required)
- ☐ Clinical Record (required)
- ☐ Progress Notes
- ☐ Treatment Plan
- ☐ Assessments
- ☐ Doctor's Orders

Interviews conducted with staff or others:

ORR action

ORR has reviewed the information pertaining to the death of this recipient and:

☐ Is opening an investigation

☐ Is not opening an investigation at this time. The office may open an investigation if new evidence is presented.

_____ _____

Recipient Rights Officer Date

Death Reporting Guidelines in LPHs

When a recipient dies;

1. **Psychiatric Notification of Death** - Michigan Administrative Rule 330.1274 requires licensed psychiatric hospitals/programs to report to the department all deaths - *Psychiatric Notification of Death Report* (BHCS-HFD-1036). This form must be completed and submitted to the department within five working days (recommended) from when the patient died on the psychiatric unit or at a Partial Hospitalization Program; after transfer to an acute care hospital, Emergency Department or Medical Unit; or within 48 hours of discharge from your facility.

Hospital Restraint/Seclusion Deaths – Centers for Medicare and Medicaid Services (CMS) requires (S&C: 14-27) all hospitals, including psychiatric hospitals, to report (by close of next business day) deaths associated with restraint and/or seclusion on form CMS-10455. Submit reports either via fax at 443-380-8952 or confidential email at 05RESTRAINTRF@CMS.HHS.GOV. Hospitals should attach an additional page to the worksheet to further describe circumstances surrounding the death (e.g., reason for restraint, total length of time in restraints, how patient was monitored, and frequency of monitoring while in restraint). Hospitals should not call to report a death. Questions may be directed to CMS ROV Chicago, Sylvia Publ, 312-353-9815 or via email sylvia.publ@cms.hhs.gov. Please note that reports contain personal health information and should be sent via a secure method.

If the death is due to a suicide, homicide or is unexpected (fall, accident): Call within 24 hrs, send the death review report within 14 days.
If the death is expected or anticipated, only the 14 day death review report is required.

http://www.michigan.gov/lara/0,4601,7-154-35299_63294_63302-314257--,00.html

Rights Office Responsibilities:

1. Review the progress notes
2. Review the Treatment Plan
3. Review doctor's orders and assessments
4. Review the Death Review Report.

ORR has reviewed this Death Report and
☐ is opening an investigation
☐ is not opening an investigation at this time. The office may open an investigation if new evidence is presented.

_____

Signature/Rights Officer

LARA Use Only

Date Received
Facility Number

PSYCHIATRIC NOTIFICATION OF DEATH REPORT
Psychiatric Inpatient Hospital/Unit

Michigan Department of Licensing and Regulatory Affairs (LARA)
Bureau of Health Care Services
Health Facilities Division
611 W. Ottawa Street, P. O. Box 30664
Lansing, MI 48909

Rule 330.1274 requires the administrator, or designee, to inform the department, as soon as administratively possible, of all deaths in the licensed psychiatric hospital unit.

Reporting Hospital				**Report Date**
(Name)				(mm/dd/yyyy)
(Address)				
(City)		(State)	(ZIP Code)	(Phone)
Hospital/Program Administrator				
(Name)				(Phone)
Initials of Patient	Medical Record #	Age	Gender (M/F)	Admission Date (mm/dd/yyyy)
Axis I admitting diagnosis:				
Axis III admitting diagnosis:				
Cause of Death			Time of Death	Date of Death (mm/dd/yyyy)

Provide brief statement of circumstances of the patient's admission to the psychiatric program:

*Attach copy of Admission History and Physical (Attachment #1)

If patient expired after discharge/transfer from the licensed psychiatric program, please note the date of discharge/transfer and location/program to which the patient was transferred/discharged.

* Attach copies of all (medical/psychiatric) discharge or transfer summaries (Attachment #2)

While hospitalized in the psychiatric or medical unit, was the patient secluded or restrained?

☐ Yes ☐ No If yes, note type of intervention(s) and date(s):

Did the death:
☐ occur while the patient was restrained or secluded, or
☐ occur within 24 hours after the patient was restrained or secluded, or
☐ occur within 1 week after the patient was restrained or secluded.

Did the use of restraint or seclusion contributed directly or indirectly to the death?

☐ No ☐ Unknown pending completion of investigation ☐ Yes

If a patient died in the community, provide the location or address where patient died, manner of death, manner of discovery of patient's death, occurrence of any events that may have contributed or precipitated the patient's death.

Provide description of life saving measures taken by hospital.

At the time of death, was the patient on a "DO NOT RESUSCITATE [DNR]" status?

☐ No ☐ Yes If YES, note:

(i) the date that the patient was placed on the DNRs status (mm/dd/yyyy)

(ii) the relationship of the individual authorizing the DNR status

Was the program's recipient rights advisor notified of the patient's death? ☐ No ☐ Yes

If yes, please note the date and time of notification: (mm/dd/yyyy) (time)

Steps taken by hospital to investigate the circumstances of the patient's death and review the quality and appropriateness of care provided to the patient.

Was local law enforcement agency notified of the patient's death? ☐ No ☐ Yes

If yes, indicate name and phone number of investigating officer(s) and name of law enforcement jurisdiction.

Was the medical examiner (ME) notified of the patient's death? ☐ No ☐ Yes

If yes, did ME take jurisdiction of this case? ☐ No ☐ Yes

If yes, provide ME office phone number, ME Case/Post #, and ME name/contact person.

* Forward copy of the postmortem report when received by the hospital.

To your knowledge, was an autopsy completed? ☐ No ☐ Yes ☐ Not Sure

If yes, by whom:

Send completed form to:

MI Dept of Licensing & Regulatory Affairs
Bureau of Health Care Services
Health Facilities Division
P.O. BOX 30664
Lansing, Michigan 48909

Submitting Authority:

_____

(Patient's physician/chief of psychiatry sign)

(Type name of signing physician)

The Michigan Department of Licensing and Regulatory Affairs will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability, or political beliefs. You may make your needs known to this Agency under the *Americans with Disabilities Act* if you need assistance with reading, writing, hearing, etc.

Form Approved
OMB No. 0938-1210

REPORT OF A HOSPITAL DEATH ASSOCIATED WITH RESTRAINT OR SECLUSION

A. Hospital Information:

Hospital Name	CCN

Address

City	State	Zip Code

Person Filing the Report	Filer's Phone Number

B. Patient Information:

Name	Date of Birth

Primary Diagnosis(es)

Medical Record Number	Date of Admission	Date of Death

Cause of Death

C. Restraint Information *(check only one)*:

☐ While in Restraint, Seclusion, or Both
☐ Within 24 Hours of Removal of Restraint, Seclusion, or Both
☐ Within 1 Week, Where Restraint, Seclusion or Both Contributed to the Patient's Death

Type *(check all that apply)*:
☐ Physical Restraint ☐ Seclusion ☐ Drug Used as a Restraint

If Physical Restraint(s), Type *(check all that apply)*:

☐ 01 Side Rails
☐ 02 Two Point, Soft Wrist
☐ 03 Two Point, Hard Wrist
☐ 04 Four Point, Soft Restraints
☐ 05 Four Point, Hard Restraints
☐ 06 Forced Medication Holds
☐ 07 Therapeutic Holds
☐ 08 Take-downs
☐ 09 Other Physical Holds (specify): _____
☐ 10 Enclosed Beds
☐ 11 Vest Restraints
☐ 12 Elbow Immobilizers
☐ 13 Law Enforcement Restraints

If Drug Used as Restraint:

Drug Name	Dosage

C. The CMHSP shall submit a written review of death for every recipient whose death occurred within six (6) months of the recipient's discharge from a state-operated service. The review shall include:
    1. Recipient's name
    2. Gender
    3. Date of birth
    4. Date, time, place of death
    5. Diagnoses (mental and physical)
    6. Cause of death
    7. Recent changes in medical or psychiatric status, including notation of most recent hospitalization
    8. Summary of condition and treatment (programs and services being provided to the recipient) preceding death
    9. Any other relevant history
    10. Autopsy findings if one was performed and available
    11. Any action taken as a result of the death

D. Should additional statistical or management information from data currently collected by the CMHSP be required by the MDHHS, at least 45 days written notice shall be provided. The written request shall identify who is making the request and the purpose of the request. The MDHHS shall make earnest efforts not to request additional information (above and/or beyond what is required in this contract and/or any modification of the contract informational requirements). Particular exceptions include additional informational requirements issued by funding and regulatory sources and/or resulting from legislative action.