

Death and Documentation

1. When called for a patient's death, ascertain that the patient is unresponsive to verbal and tactile stimuli without spontaneous respirations (visually and by auscultation), is pulseless and without heart sounds, and that pupillary reactivity is absent. Furthermore, ensure that you have the correct name by ID bracelet.
2. Notify the attending MD, unless the death was expected and you were specifically informed that this wasn't necessary.
3. Notify the next of kin and determine whether an autopsy is desired, also determine whether the family would like to view the body prior to transport to the morgue. It may help the family member to inform them that the patient died peacefully, etc., if this was the case. Have the family sign the release of body (even if they have not yet made funeral arrangements), autopsy request/refusal, valuables forms. Do this ASAP so the family can grieve in peace.
4. Call the coroner according to the reasons below. If in doubt, call the coroner. If a case is felt to be a coroner case, neither you nor the family may touch anything immediately surrounding the patient. It is considered tampering.
5. Fill out the discharge summary, discharge orders, death note in the chart, death certificate which must be done by a licensed physician (if death is imminent for one of your patients, please leave a completed discharge paperwork upon signout as a courtesy to your colleagues). Ask the nurses for help.

Deaths reportable to Coroner (California Government Code section 27491)

1. If patient has not been seen by a physician (or palliative care RN) in the past 20 days
2. If death <24hr in hospital
3. Suspected criminal act
4. Accidental poisoning
5. Controlled substance
6. Occupational disease
7. Contagious disease as the cause of death
8. Death in OR or not fully recovered from anesthesia
9. Prisoners (in custody)
10. Unidentified people
11. Cases where physician is unable to state the cause of death.

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