



ED Registration Death Process

1. The **Discharge** will print out on ED Registration printer(similar to the old discharge/death communications). It should be kept with the paper work and filed in the death binder once the body has been released.

Baseline West Medical Center
123 Holly Way
Kansas City, MO 64117

Patient Information

MRN:	
Name:	FIN:
Location:	Admit Date:
Room:	Attending MD:
Date of Birth:	Ordering MD:
Age:	LOS:
Sex:	
Height:	
Weight:	
Admitting Diagnosis:	
Allergies: No Allergy Information Has Been Recorded.	

Ordering Information Order Action: **Order**

Order: DISCHARGE PATIENT
Requested Start Date/Time:
Discharge Patient To: Home with support
Special Instructions:
Order ID:

Comments:

Ordered By:	Order Date/Time:
	Communication Type: verbal with Read Back (Cosgr)



2. If the “Discharge patient to” field is equal to one of the following it is your new “death notification”.
 - a. “Died in facility”
 - b. “Died on arrival (DOA)”
 - c. “Died while on pass/leave”
 - d. “Died with MAID”

All discharge print outs that do **NOT** have a “discharge patient to” of “died” should be kept for five days and can then be shredded.

Baseline West Medical Center
123 Holly Way
Kansas City, MO 64117

Patient Information

MRN:	
Name:	PN:
Location:	Admit Date:
Room:	Attending MD:
State of Birth:	Ordering MD:
Age:	LOS:
Sex:	
Height:	
Weight:	
Admitting Diagnosis:	
Allergies: No Allergy Information Has Been Recorded.	

Ordering Information Order Action: Order

Order: DISCHARGE PATIENT
Discharge Patient To: Home with support
Order ID:

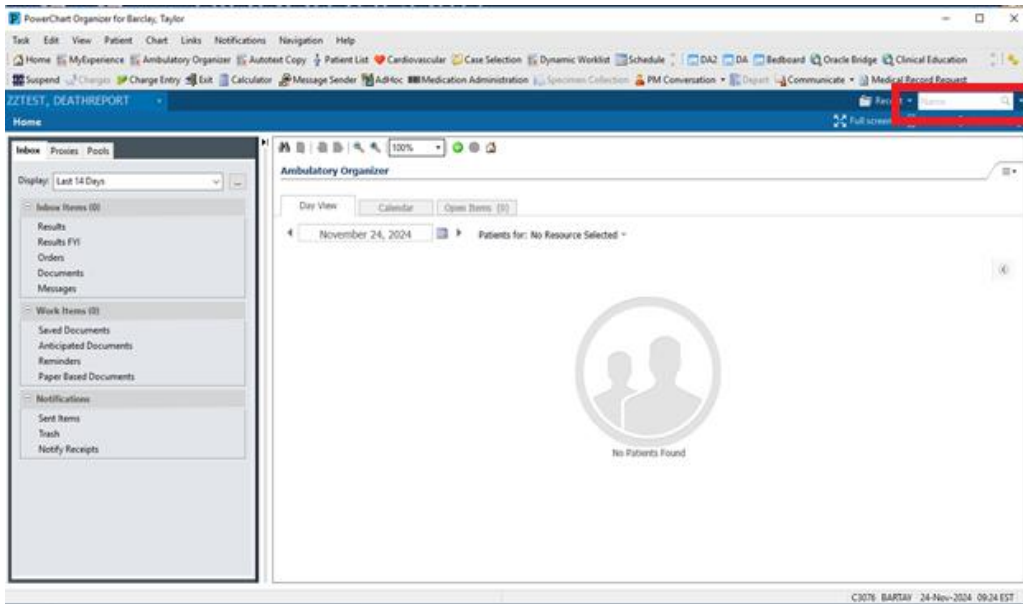
Comments:

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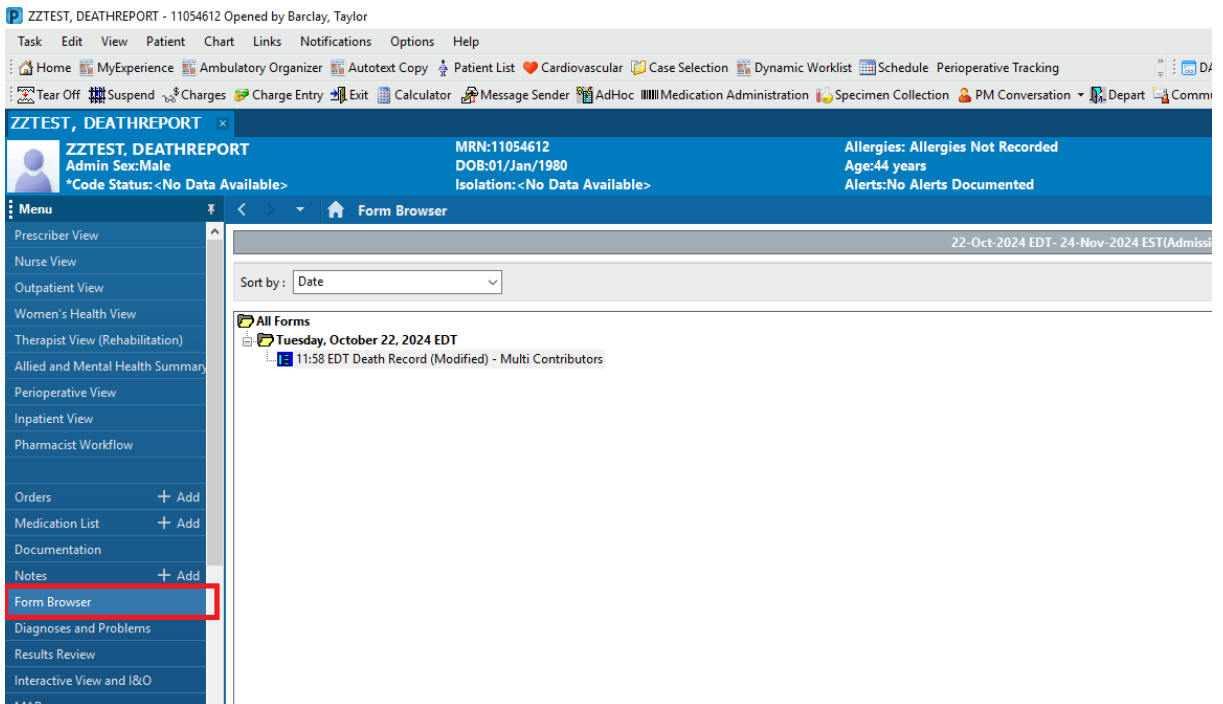
Ordered By: Order Date/Time:
Communication Type: verbal with Read Back (Coag)



3. At this time, sign into **powerchart**. Beside the search field click on the **arrow** and change from Name to FIN. Then enter the FIN in the search field to open the patient chart.



4. Along the left-hand side in the blue section select "Form Browser".

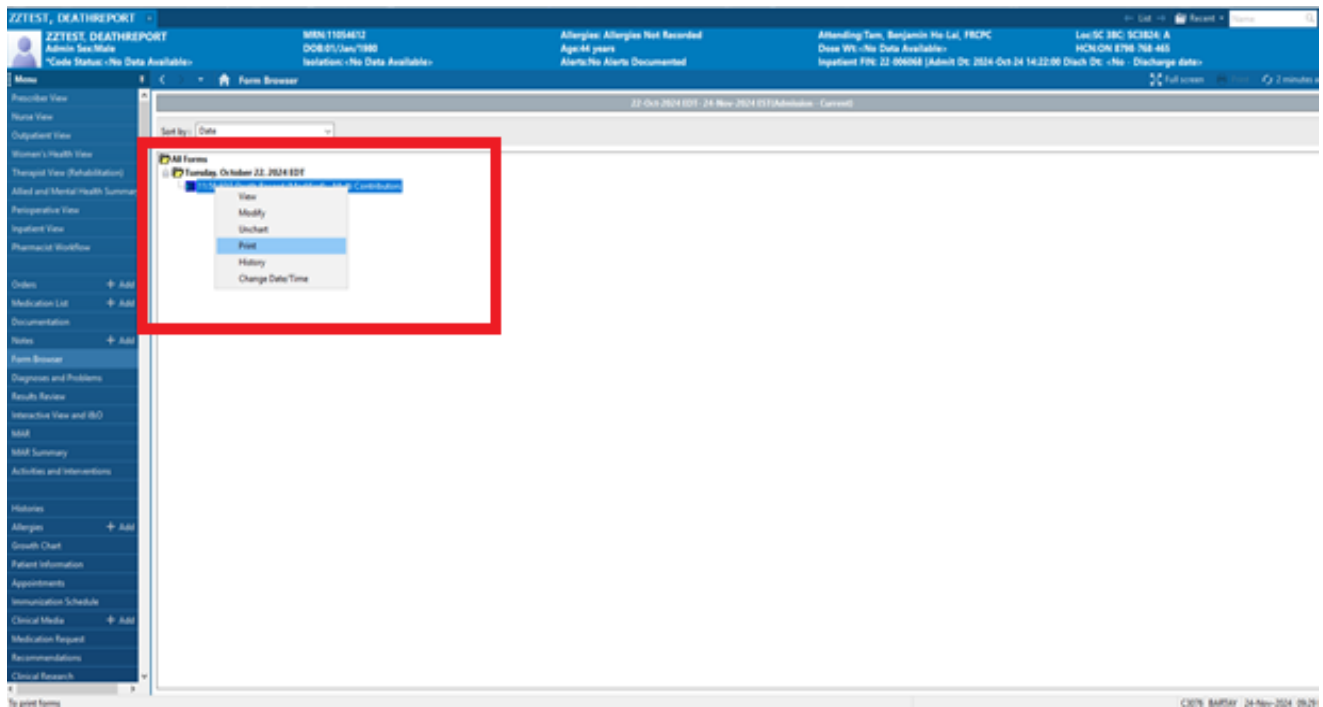




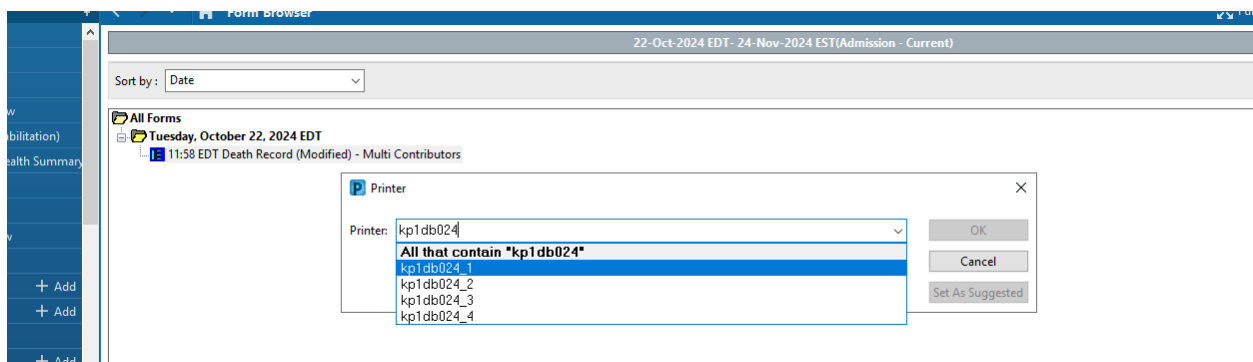
5. Within the All Forms list find “Death Record”.



6. Right click on Death Record and select “Print”.



7. Type in the printer name and tray that the Death Record should print on.





- This is what the printed Death Record looks like. It includes every field that nursing has filled out within the power form. Use this to fill out the Death Check List. If there are any details missing, it means the field was missed in the form, call the floor to get the details and update the power form. This form should be filed with the checklist in the death binder once the body has been released.

Death Record
 22/10/24 11:58 EDT Performed by NHS Test02, Nurse - Critical Care
 Entered on 22/10/24 12:00 EDT

Updated on
 24/10/24 10:11 EDT by NHS Test02, Nurse

Notification
 Pronounced by: NHS Test01, Nurse
 Date/Time of Death: 22/10/24 11:59
 Name of Attending Notified of Death: Sangha, Navjeet Singh, MD
 Date/Time Attending Notified of Death: 22/10/24 11:59
 Notifications of Death: Attending physician, Family member, Trillium Gift of Life network
 Death Certificate Status: To be completed
 TGLN #: 123456789
 Date/Time Trillium Notified: 22/10/24 11:59
 Death Record Physician Instructions: No autopsy required, Release body to morgue, Release body to funeral home
 Name of Family Member Notified of Death: Test
 Date/Time Family Notified of Death: 22/10/24 11:59
 Relationship to Deceased: Family member
 Family Phone Number Expiration Record: 1234567890
 Coroner:

Death Meets ME Criteria?: Yes
 Death Record Warrant to Bury: N/A
 Name of ME Notified of Death: test
 Date/Time of Notification: 24/10/24 10:10
 Coroner Instructions: No autopsy required, Release body to morgue, Forensic autopsy required

Infectious Disease
 Infectious Diseases at Death: Not applicable

Autopsy
 Autopsy: Requested by physician, Requested by coroner, Requested by family member
 Hospital Autopsy?: Yes
 Hospital Autopsy Consent Signed?: Yes
 Drains and Invasive Lines in Place?: Yes
 Pathologist Notified: test
 Date/Time of Notification: 24/10/24 10:10
 Planned Autopsy Date: 24/10/24 10:10
 Autopsy Performed Date: 24/10/24 10:10

Disposition
 Name of Funeral Home: Test Funeral Home
 Funeral Home Phone Number: 1234567890
 Date/Time Body Left Department: 22/10/24 12:00
 Body Transported: To morgue
 Belongings Sent Home With Dispo: Test Spouse
 Belongings Sent Home: No
 Body Transported By: Porter, Other: security guard

SCS(Location:SC 3BC ; SC3B24 ; A)
 Patient Name: ZZTEST, DEATHREPORT DOB / AGE / SEX: 01/01/80 44 Years Male
 Admitting Physician: Tam, Benjamin Ho-Lal, FRCPC
 Admission Date / MRN / Financial Num: 22/10/24 11054612 22006068

Page 1 of 1
 Print Date: 24/11/24
 Print Time: 09:52 EST
 Printed by:Barclay, Taylor

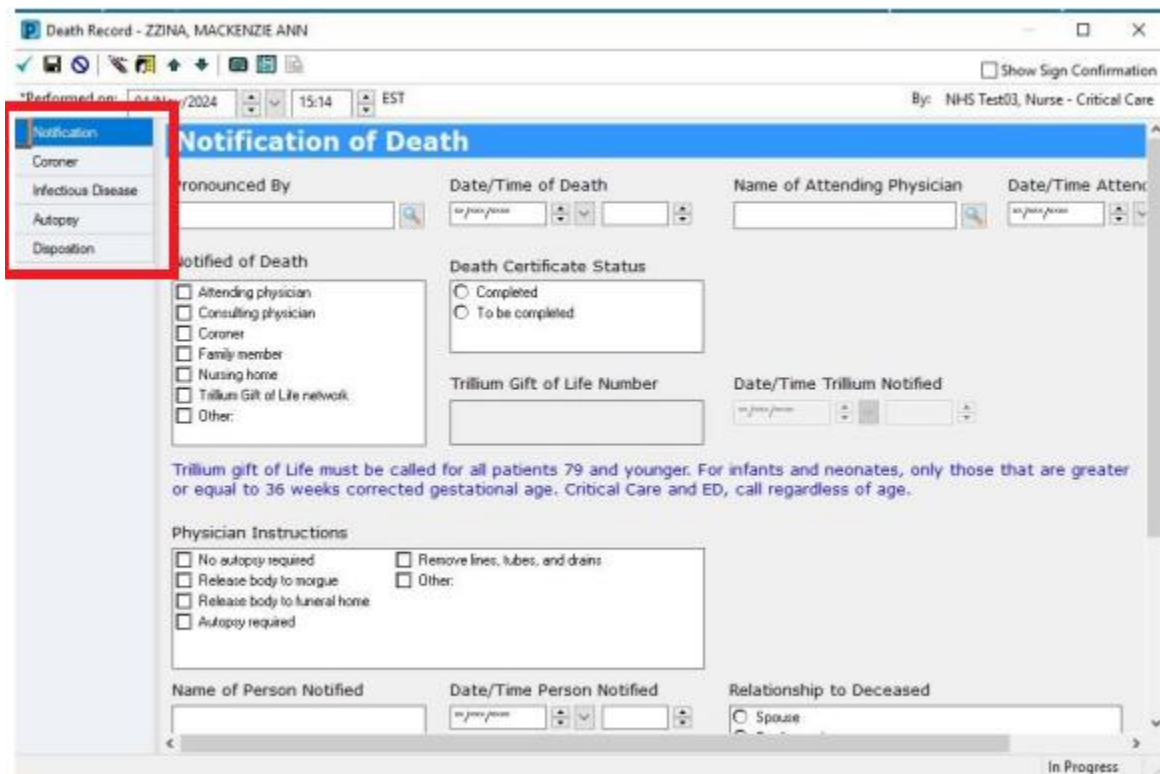
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9. In the event there is a need to view the Death Record to check for missing information, double click on the “**Death Record**” and it will open the electronic version.



10. The Death Record is divided into sections. On the left-hand side click on the section to view it.



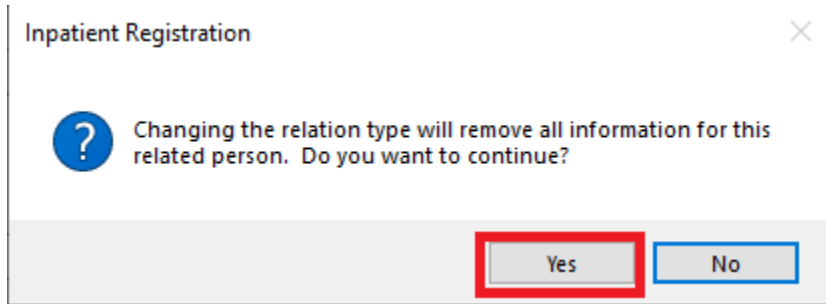
Once the death checklist is completed with the information in the Death Record, continue with current workflow to facilitate the release of the body.

ADDING “ESTATE OF” TO THE GUARANTOR

1. Sign in to Access Management Office/Conversation Launcher.
2. The Patient must be discharged (maybe wait until you receive the Morgue sign in/out sheet from Security as a trigger to do this step), choose the “Modify Discharged Encounter” conversation.



3. Navigate to the Primary Insurance tab, scroll down to the Guarantor section.
4. Change “Relationship to patient” field to “**Self-Billing Address**”
5. Select “Yes” to the pop-up below. It will clear the fields.



6. In the “Last Name” field type “**Estate of** “ (do not include the quotes) and re-type Last Name, then re-type the First Name. It should look like this.

A screenshot of a software interface showing the 'Guarantor' section. The section is titled 'Guarantor' and contains three input fields. The first field is labeled '* Relationship To Patient:' and has a dropdown menu with 'Self-Billing Address' selected. The second field is labeled '* Last Name:' and contains the text 'ESTATE OF ZZTEST'. The third field is labeled '* First Name:' and contains the text 'DEATHREPORT'. Below these fields, there is a partially visible label 'Send Bill To:'.

7. In the “Street Address” field type “same” this will copy the patient address from the patient information tab.
8. Click “OK” to file the conversation, there will be a pop-up warning you that the patient is over 18 and the relationship to patient is not SELF. It asks if you want to change the Guarantor, you will select “NO” because you have already changed the information to what it needs to be. If you select “YES” by accident it will force you back to the Guarantor section, just repeat the previous steps in step 8.