CLIENT / PATIENT / RESIDENT REPORTABLE DEATH DETERMINATION

For Reportable Deaths Related to the Use of Physical Restraint/Seclusion, Psychotropic Medication, or Suicide

DHS USE ONLY	Screening Date:	Investigation Due Date:	Death Report No.:
	☐ NI – Not Reportable ☐ EA – Event Analysis (BHS) ☐ IN – Assigned to Region / Surveyor		
	Referral – DQA Bureau / Section / Region:	Other:	

See Section V, *General Information and Death Determination Guidelines*, before completing this form.

I. DECEASED

Name – **Deceased** (Last, First, MI)		Date – **Death** *(MM/dd/yyyy)*
Date – Birth *(MM/dd/yyyy)*	Sex ☐ Male ☐ Female	Date – Admission *(MM/dd/yyyy)*

Ethnicity *(Check one.)*

☐ American Indian / Alaskan Native ☐ Black *(Not Hispanic)* ☐ Hispanic *(Mexican, Puerto Rican, Cuban)*
☐ Asian or Pacific Islander ☐ White *(Not Hispanic)*

II. PROVIDER *(List agency, clinic, or facility providing care services to deceased.)*

Name – **Agency / Clinic / Facility**			**Certification / License No.**
Address – Street Address	City	County	State / Zip Code

Provider Type *[Check provider type(s) with which the client/patient/resident was enrolled at the time of death.]*

			Wis. Admin. Code
☐	1.	Emergency Mental Health Service	DHS 34
☐	2.	Outpatient Mental Health Clinic	DHS 35
☐	3.	CCS for Persons with Mental Health and Substance Use Disorders	DHS 36
☐	4.	Mental Health Day Treatment Services for Children	DHS 40
☐	5.	Mental Health Inpatient – Adult / Adolescent	DHS 61.71, 61.79
☐	6.	Mental Health Day Treatment	DHS 61.75
☐	7.	CSP for Persons with Chronic Mental Illness	DHS 63
☐	8.	CSAS Emergency Outpatient Service	DHS 75.05
☐	9.	CSAS Medically Managed Inpatient Detoxification Service	DHS 75.06
☐	10.	CSAS Medically Monitored Residential Detoxification Service	DHS 75.07
☐	11.	CSAS Ambulatory Detoxification Service	DHS 75.08
☐	12.	CSAS Residential Intoxication Monitoring Service	DHS 75.09
☐	13.	CSAS Medically Managed Inpatient Treatment Service	DHS 75.10
☐	14.	CSAS Medically Monitored Treatment Service	DHS 75.11
☐	15.	CSAS Day Treatment Service	DHS 75.12
☐	16.	CSAS Outpatient Treatment Service	DHS 75.13
☐	17.	CSAS Transitional Residential Treatment Service	DHS 75.14
☐	18.	CSAS Narcotic Treatment Service for Opiate Addiction	DHS 75.15
☐	19.	Community-based Residential Facility	DHS 83
☐	20.	Adult Family Home	DHS 88
☐	21.	Nursing Home	DHS 132
☐	22.	Facility Serving People with Developmental Disabilities	DHS 134

III. DETERMINATION

Check "Yes" or "No" for each item in sections A – C. For assistance, see "Death Determination Guidelines" in Section V.

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?

☐ Y ☐ N 3. Did the physician discontinue a psychotropic medication within the last thirty days?

☐ Y ☐ N 4. Did the client/patient/resident refuse psychotropic medications within the last thirty days?

☐ Y ☐ N 5. Was the client/patient/resident changed to a different psychotropic medication within the last thirty days?

☐ Y ☐ N 6. Did the client/patient/resident's medical/psychiatric condition change in the last thirty days, based on observed symptoms and behaviors?

☐ 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 thirty days?

☐ Y ☐ N 8. Did the client/patient/resident present any signs which would indicate the possibility of neuroleptic malignant syndrome (NMS)?

☐ Y ☐ N 9. Was a psychotropic medication given with no valid diagnosis for the drug?

C. Physical Restraints and Seclusion

☐ 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?

IV. REPORTING

Name – **Person Reporting**	Title	Email Address		
Address – Street	City	State	Zip Code	Telephone No.

Have you previously reported this death to the Department of Health Services? ☐ Yes ☐ No *If yes, provide:*

Name – Person to Whom Reported	Telephone No.	*Date Reported (MM/dd/yyy)*

Method of Reporting: ☐ Telephone ☐ Email ☐ Other

Is there a person in your agency who was involved in the client/patient/resident case who might have more information about the death (e.g., therapist, manager, social worker)? ☐ Yes ☐ No *If "yes," provide:*

Name	Title
Telephone No.	Email Address

Was this death reported to the coroner / medical examiner? ☐ Yes ☐ No *If yes, complete:*

Name – Coroner / Medical Examiner	County	Telephone No.

Summary (Mandatory)

Provide a brief summary of the circumstances surrounding the death. You may attach a copy of progress notes or other documentation that provide additional information used to determine whether there is reasonable cause to believe that the death was due to the use of physical restraints / seclusion, psychotropic medication, or suicide.

SIGNATURE – Person Completing Form	Date Signed
➢	

For additional information about reporting a death, call **608-261-8319** or visit the DHS webpages at: https://www.dhs.wisconsin.gov/regulations/report-death/proc-reportingdeath.htm

Submit this fully completed form by fax or email to: **Department of Health Services**
Division of Quality Assurance / Office of Caregiver Quality
Fax: 608-264-6340
Email: DHSCaregiverIntake@dhs.wisconsin.gov

V. GENERAL INFORMATION AND DEATH DETERMINATION GUIDELINES

GENERAL INFORMATION

- Per Wisconsin State Statutes, certain providers are required to report deaths related to the use of physical restraint/seclusion, psychotropic medication, or suicide to the Department of Health Services (DHS) within 24 hours of learning of the death.
- For programs and providers that are required to utilize this form, see "Provider Type" in Section II.
  - **Community-Based Residential Facility** – Wis. Stat. § 50.035(5)(b)
  - **Adult Family Home** – Wis. Admin. Code § DHS 88.03(5)(e)1
  - **Nursing Home** – Wis. Stat. § 50.04(2t)(b)
  - **Treatment Facility** (mental health or substance abuse program / service) – Wis. Stat. § 51.64(2)(a)
  - **Hospital** (restraint / seclusion deaths) – 42 CFR and 482.13(g)

    Deaths associated with restraint and/or seclusion are to be reported directly to the Centers for Medicare and Medicaid Services (CMS) Regional Office. See S&C-14-27-Hospital-CAH/DPU at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions-Items/Survey-and-Cert-Letter-14-27-.html?DLPage=1&DLEntries=10&DLFilter=14-27&DLSort=3&DLSortDir=descending.
- When in doubt as to whether a death is due to the use of physical restraint/seclusion, psychotropic medication, or suicide, report the death to DHS.
- Failure to report such deaths to DHS may result in a citation of noncompliance by the department.
- The information obtained from this form will be used for investigative and statistical purposes only and personal health information will be available only to those persons legally authorized to access treatment records.

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/resident 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/patient/resident 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/patient/resident 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/patient/resident 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/patient/resident 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., criticism, rejection

B. Psychotropic Medications

1. Psychotropic Medication means 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 are 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/patient/resident 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

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/patient/resident complains of an increased temperature and muscular rigidity
k. Fatal heatstroke, especially if client/patient/resident is on Thorazine
l. History of difficult-to-control epilepsy
m. Jaundiced skin and sclera
n. Any medication error in proximity to time of client/patient/resident death

3. Neuroleptic Malignant Syndrome (NMS) (See: http://rarediseases.org/rare-diseases/neuroleptic-malignant-syndrome)
Per the National Organization for Rare Disorders (NORD), the diagnosis of neuroleptic malignant syndrome is based on the presence of characteristics that include treatment with neuroleptic drugs within the past 1-4 weeks, high body temperature greater than 38 degrees centigrade, muscle rigidity, and at least five of the following:
a. Change in mental state
b. Rapid heartbeat (tachycardia)
c. Low or high blood pressure (hypo- or hypertension)
d. Excessive sweating (diaphoresis)
e. Excessive saliva production (sialorrhea)
f. Tremor
g. Incontinence
h. Increased creatine phosphokinase or increased urinary myoglobin
i. Increased number of white blood cells (leukocytosis)
j. Increased concentration of metabolic acids in blood and urine
k. Exclusion of other drug-induced psychiatric or systemic illness

C. Physical Restraints and Seclusion

1. Presence of one or more of the following indicators:
a. Client/patient/resident found suspended by/from restraint
b. Client/patient/resident found sliding from bed, wheelchair, or chair
c. Client/patient/resident neck / head found under/between side rails
d. Client/patient/resident 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/patient/resident 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/patient/resident

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