

Policy and Procedure Milwaukee County Housing Division	Date Issued 03/18/2015	Policy Number HOUSING - 103	Page 1
	Date Revised	Subject: Death Reporting Policy	

1. POLICY:

PURPOSE: To be informed of and monitor client deaths in Housing Division programs, both Division-operated and Provider Network agencies, for purposes of ongoing quality assurance and performance improvement.

POLICY: The Housing Division shall be informed in writing and by phone contact of any death of a client in service in Housing Division-operated and Provider Network agencies within 24 hours of discovery of death, on the first business day following the death.

2. PROCEDURE:

Programs are to notify the Housing Division of any death of a client in service within 24 hours of discovery of the death, on the first business day following the death.

A. Housing programs are to complete and submit the following forms:

1. Notification of Death Form to the Housing Division, within 24 hours of discovery of death, or on the first business day following the death.
2. Incident report should be sent to the Housing Division.
3. In the case of a death believed to be caused by suicide, psychotropic medication or physical restraint/seclusion, programs having the regulatory reporting requirement to notify the State should report the death to the Division of Quality Assurance, Wisconsin Department of Health and Family Services, within 24 hours of the death (see Client/Patient Death Determination Form DSL-2470). The Standard of Practice for Housing Division- operated programs has been to complete this form and notify the State on all deaths that occur in any of the Housing Division-operated programs. A copy of the Client/Patient Death Determination Form DSL-2470 should be forwarded to the Housing Division.
4. Other Notifications: each Housing Division Operated Program will notify the Housing Division Special Needs Housing Manager, in the event a death occurs in the respective program.

B. Housing-Provider Network agencies are to complete and submit the following forms:

1. Notification of Death Form to the Housing Division, within 24 hours of discovery of death, or on the first business day following the death.
2. In the case of a death believed to be caused by suicide, psychotropic medication or physical restraint/seclusion, programs having the regulatory reporting requirement to notify the State should report the death to the Division of Quality Assurance, Wisconsin Department of Health and Family Services, within 24 hours of the death (see Client/Patient Death Determination Form DSL-2470). A copy of the completed form should be forwarded to the Housing Division.
3. A Copy of Coroner/Medical Examiner's report to the Housing Division when available.

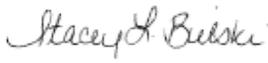
Policy and Procedure Milwaukee County Housing Division	Date Issued 03/18/2015	Policy Number HOUSING - 103	Page 2
	Date Revised	Subject: Death Reporting Policy	

4. Other Notifications: each Housing Division Provider Network Agency will notify the Special Needs Housing Manager in the event a death occurs in the agency.

C. Quality Assurance Process

1. Housing Division Provider Network agencies are to have a quality/risk management process in place for internal review of client deaths. Following the death of a client, the agency is to complete their internal review and submit a brief written summary of findings. This summary may include: treatment and service delivery at time of death, evaluation of those services, and recommendations for changes in services or treatment. This summary is to be sent to the Housing Division.
2. Housing-operated programs are subject to the existing Housing and DHHS Quality/Risk Management policy and procedure governing critical incident review.
3. The Housing Division, through psychiatric social workers, will review the reports of client deaths and forward problematic cases to the BHD Critical Incident Committee if necessary.
4. The Housing Division reserves the right to explore all reports of client deaths.

Attachment 1: Notification of Death Form

Reviewed & Approved by: 
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NOTIFICATION OF DEATH

Consumer: _____ **MR/Client #:** _____

Gender: Male Female Date of Birth: _____ Age: _____

RU#: _____ Provider Agency: _____

Agency Admission Date: _____ Agency Contact & Phone #: _____

Date of Death (If Known): _____ Date of Agency's Discovery of Death: _____

Cause of Death (If Known): Natural Suicide Homicide Unknown Other _____

I. Circumstances of Death (location, anticipated/unanticipated): _____

Describe Actions Taken: _____

Notifications Made: _____ Coroner / Medical Examiner
_____ Sheriff / Police
_____ State of WI DHSS Client/Patient Death Determination
(Please attach copy of completed form)

II. Diagnoses

Axis I. _____

Axis II. _____

Axis III. _____

III. Current Behavioral Health Condition / Treatment

A. List of Most Recent Medications: _____

Medications Changes within the Last Seven Days: _____

B. Current Service Delivery (Include Frequency, Intensity, Type and Date of Last Contact): _____

C. Describe any Significant Changes in Client's Behavioral Health in the Last Month based on Observed or Reported Symptoms and Behaviors: _____
