WHITING FORENSIC HOSPITAL
NURSING MANUAL

SECTION D:	PSYCHOLOGICAL ADAPTATION
CHAPTER 14:	Death and Dying
PROCEDURE 14.3	**Post Mortem Care**
Governing Body Approval:	3/8/19
REVISED:	3/8/19

Standard of Practice:

The Registered Nurse will ensure that post mortem care to the deceased is done in a respectful, private, and safe manner.

Policy:

All Nursing staff will provide post mortem care in a respectful, private, and safe manner.

Procedure:

A. A patient must be seen by a licensed physician to be officially pronounced dead. In cases of sudden death, accident, suicide, or where negligence or homicide may be involved, the State Medical Examiner must be informed by the physician before a body can be moved or given post mortem care. The physician is responsible to notify the Nursing Supervisor when post mortem care may be performed.

1. Prepare the body for transfer. Physician will order one of the following:
   a. Medical examiner
   b. Funeral home (no autopsy)
   c. General hospital for pathological diagnosis by autopsy

- Ensure proper identification of the deceased.
- Safeguard the belongings of the deceased.
- Determine the disposition of those belongings.
- Protect staff from undiagnosed or unidentified infections.
- Equipment and action:
  - Screen, if private room is not available
  - Bathing articles (water, towel, soap, washcloth, basin)
  - Zip-bag style shroud kit (available from switchboard)
  - Protective barriers (gown, apron, gloves, face shield)
  - Containers for belongings (bags, boxes, envelopes)

- Pen

2. Universal Precautions are to be taken and all protective barriers worn.

3. Guidelines:
   a. Screen the bed or close the door if in a private room.
   b. Place the body in a supine position, arms at the side, head on the pillow.
   c. Close the patient's eyes by gently pressing on the lids with your gloved fingertips. If they do not stay closed, place moist cotton balls on the eyelids for a few minutes and try again.

   d. If dentures are out, do not insert them. Place them in a labeled container. **If dentures are in, leave them in place**.

   e. Remove earrings, rings and other personal articles and place in a separate labeled container. If the family has requested that rings be left on the body, secure them with a piece of gauze.

   f. Remove indwelling catheters, tubes, dressings and drains. Dispose of these in a paper trash bag.

   g. Give a bed-bath to the patient. Comb the patient's hair.

   h. Place pads between buttocks to absorb rectal drainage.

   i. Pad wrists and ankles, cross them and tie them with gauze.

   j. Place one identification tag on the large toe. The tag should identify the patient's name, the date and time of death, unit number and any known communicable diseases.

   k. Place shroud on stretcher, and after obtaining assistance, transfer the body to the stretcher. Close shroud and tie a second identification tag to the waist area. This tag should have the same information as the toe tag.

   l. Check the patient's clothing with the clothing record and then mark it with "deceased" and date it.

   m. Place clothing and other labeled items (dentures, eyeglasses, and valuables) in a large bag and tie securely with another identification tag.

   n. Notify the nursing supervisor that the body is ready.

   o. A copy of the property/clothing record, clothing and valuables are kept in the unit office pending notification of family/conservator for disposition.

p. Send money to Patient's Accounts.

4. The Nurse Supervisor is to be aware of the name of the patient, whether Last Rites were administered, the name of the pronouncing physician, whether or not an autopsy is to be done, if the clothing and belongings are all accounted for, and their disposition.

B. Charting:

1. In the Integrated Progress Notes, record the time the patient was pronounced dead and the name of the physician.

2. Record notifications made by the physician, e.g., CEO, WFH Agency Police, Conservator, Funeral Home, Medical Examiner and the family.

3. Record whether or not the body was claimed or examined by the Medical Examiner.

4. **Record disposition of body, i.e., name of funerals home, etc.**

5. Record that post mortem care was given.

6. Record the disposition of the belongings.