SPECIAL CONSIDERATIONS

For Hospitals Updating Fatality Management Plans in New York City

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BACKGROUND

All New York City (NYC) hospitals had pre-existing fatality management plans and protocols in place prior to the COVID-19 pandemic that were based on the NYC Office of Chief Medical Examiner's (OCME) Biological Incident Surge Plan for Managing In-Hospital Deaths. Given the lessons learned during the initial COVID-19 patient surge, City agencies involved in fatality management operations are revising their plans. Hospitals and health systems are encouraged to similarly update and revise their internal plans.

PURPOSE

This *Special Considerations* document is intended to help hospitals update their plans by drawing attention to specific issues. Separately, the City, OCME, NYC Emergency Management (NYCEM), and other agencies are addressing issues within their plans and processes to improve fatality management operations moving forward.

UPDATE FATALITY MANAGEMENT CONTACTS

Challenge

All hospitals previously identified points of contact (POCs) within their existing plans, but many of these contacts were no longer valid due to staffing changes. In addition, given the scope of the COVID-19 fatality surge, various departments were involved in fatality management operations—including mortuary staff, emergency managers, admitting departments, and hospital management/leadership. Existing plans did not always include POCs for these various departments or a reliable structure to readily contact these departments. Both issues hampered communication between City agencies and hospitals, as well as internal staff coordination within hospitals.

Consideration

Hospitals are encouraged to update and expand the POC list provided to OCME, and to create interdepartmental fatality management teams. To support this effort, GNYHA plans to collect additional contact information via its Sit Stat 2.0 System.

DEFINE INTERNAL STRUCTURES AND ROLES

Challenge

While hospitals had various staff working on fatality management efforts, it was not always clear who was responsible for specific tasks. In addition, there was not always streamlined communication between departments, which hindered efficiency.

Consideration

Hospitals are encouraged to define key staffing roles for surge mortuary operations and identify clear triggers for activation of the team. A regular meeting should be scheduled as soon as the trigger is activated, and meetings should increase in frequency as fatalities increase. Job Action Sheets should clearly define each team member's responsibilities, and coordination among roles and departments should be detailed.

ENHANCE MANAGEMENT OF BODY COLLECTION POINTS (BCPS)

Challenge

All hospitals' pre-existing plans identified a designated location to stage a BCP, as well as a preferred size and type of BCP. However, during the COVID-19 patient surge, many NYC hospitals had to stage multiple BCPs at one time. In terms of both location and staff, most hospitals did not have plans to manage multiple BCPs onsite. Many hospitals had designated their loading dock as the staging location for the BCP in their fatality management plans, but this was not feasible because hospitals were continuously receiving supplies that needed to be delivered via the loading deck, requiring the hospital to relocate the BCP. Upon relocation, hospitals encountered difficulty placing decedents in the large trailers because they did not have lifts or ramps in place for easy movement. In addition, due to difficulties sourcing various kinds of BCPs, NYCEM often delivered BCPs that were larger than expected or were diesel as opposed to electric.

Consideration

Hospitals should identify at least three locations where BCPs can be staged in anticipation of a second wave. Contingency plans should be determined in the event that more than three BCPs need to be stored onsite at one time. Hospitals should also develop plans to build a ramp or have a lift installed that can assist in the movement of decedents. Additionally, facilities should develop plans for all potential sizes and types of BCPs that could be delivered.

SOURCE AND STORE BODY BAGS

Challenge

NYC experienced myriad supply shortages, including human remains pouches (HRPs), better known as body bags, to store decedents. Hospitals were initially able to submit a supply request to NYCEM or the Department of Health and Mental Hygiene (DOHMH) to fulfill orders for body bags, but supply was limited and not all orders could be filled. Hospitals were then advised to contact a set of vendors to source their own bags, but these vendors also had a limited supply and could not accommodate all requests. Later, OCME advised all hospitals to store decedents in disaster ruggedized heavy duty body bags in consideration of decedents being handled and moved. Unfortunately, these were also in limited supply.

Consideration

Hospitals should begin sourcing both regular and disaster body bags in order to build up an internal stockpile. While NYC is developing a large stockpile for future waves and emergencies that will include body bags, the normal resource request process will apply, with hospitals expected to exhaust all potential sources of supplies before accessing the stockpile.

SURGE MORTUARY SPACE

Challenge

While hospitals had pre-existing plans in place, these plans did not account for the unprecedented volume of decedents and extended storage times. OCME/NYCEM provided BCPs to hospitals, but this often occurred after hospitals had already surpassed their fixed morgue capacity.

Consideration

Similar to the requirement for all hospitals to increase their inpatient bed space, hospitals should also consider how to surge their mortuary space. Hospitals can add shelving to their fixed morgue to increase capacity and/or designate other areas in their hospital that could hold decedents. This will provide greater flexibility before needing to request a BCP.

MONITOR DATA AND TRENDS

Challenge

Due to the rapid surge of very sick patients and high numbers of fatalities during the initial COVID-19 wave, hospitals were frequently submitting urgent requests for an additional BCP in order to properly store decedents.

Consideration

While predicting fatalities is difficult, especially given that a future wave may look different than the initial wave, hospitals are encouraged to monitor data that will allow for forecasting of fatalities. Data such as number of intubated emergency department boarders, number of intensive care unit patients, and previous fatality rates can provide critical information that, when compared with available morgue space, can inform proactive requests for BCPs.

ESTABLISH FAMILY MANAGEMENT PLANS

Challenge

The high volume of fatalities, combined with visitation restrictions and the societal lockdown, made communicating with families and funeral directors difficult. While many hospitals had family management programs in place, it was difficult to expand them to meet the increased need. In addition, the backlog in the funeral home industry—which typically takes on a large amount of the family outreach—required a change in workflow on the hospital side.

Consideration

Hospitals should create robust family management programs or expand their existing programs. The volume of fatalities should be considered and resources should be pre-identified to expand and scale the operation.