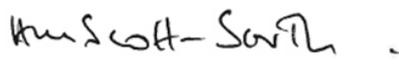


COMMUNICATION OF DECEASED PATIENTS TO PRIMARY CARE

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Burton Hospitals NHS Foundation Trust

POLICY INDEX SHEET

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Consulted	Executive and Associate Directors Senior Managers Heads of Departments Head Nurses All Matrons

REVIEW AND AMENDMENT LOG

Version	Type of change	Date	Description of Change
2	Routine Review	January 2015	Routine Review. Amendments to job titles and Divisions.
3	Routine Review	March 2018	Change of deceased patient stamp to Confirmation of Death Form

COMMUNICATION OF DECEASED PATIENTS TO PRIMARY CARE

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Burton Hospitals NHS Foundation Trust

COMMUNICATION OF DECEASED PATIENTS TO PRIMARY CARE

1. INTRODUCTION

The Trust recognises the importance of ensuring primary care representatives are fully informed in a timely manner when a patient dies within the hospital. Delays in information transfer can lead to increased distress for the family or carers who are reliant upon all agencies communicating effectively. In addition, poor communication can damage the reputation and integrity of the Trust.

This Policy will set out the standard that communication should always be made to primary care as soon as possible, but no later than 48 hours after the death occurs, or by the first working day following a weekend period – whichever is sooner.

2. SCOPE OF THE POLICY

This document sets out the Policy of Burton Hospitals NHS Foundation Trust to ensure that both its employees and primary care organisations are informed in a timely and professional manner of any patient deaths whilst under its care, working to the standards set out within this Policy. Every area within Burton Hospitals NHS Foundation Trust has a duty to ensure this standard is adhered to.

This Policy is in place to ensure clear communication channels are utilised with our partners in the local health community in order to convey accurate and current information regarding recently deceased patients. This document is important and relevant to all nurses, matrons, doctors, senior sisters, ward clerks and heads of departments.

3. POLICY OBJECTIVE

The primary objective of this Policy is to ensure that a patient's current GP and support services are informed when a death has occurred, in all instances as soon as possible, but at least within 48 hours. Should a death occur over a weekend or public holiday, then communication with all associated agencies should be made immediately following this period on the next working day.

To ensure that this standard is maintained the following are required:

- The GP and support services contact details must be correct and accessible within the patient's admission notes.

- Ward / departmental processes should be clear, accessible and easy to follow for all members of staff who are required to inform primary care providers and support services.
- Processes for recording information given including name, time, message and reporter need to be recorded using the Confirmation of Death Form (see Appendix 1 for illustration)

Senior Sisters will have the responsibility to ensure the processes are in place within their own department or area to allow timely and clear communication.

For the purposes of this Policy, 'associated agencies' or 'support services' refers to all healthcare professionals that are involved in a patient's current care plan.

4. PROCESS OF COMMUNICATING TO PRIMARY CARE

4.1 Confirmation of Death Form

All wards and departments should possess the Confirmation of Death Form, (illustration given in Appendix 1) which is to be used to identify in the notes of a recently deceased patient. The form should be applied prominently in the notes to clearly identify that a patient is deceased. The person responsible for communicating the information to primary care should complete the section 'GP informed'. This is the responsibility of the Senior Sister, although on a day to day basis, this may typically be carried out by the Ward Clerk; however it is permissible that the nurse in charge of a patient's care may also fulfil this role if required. It is recommended that the form should be completed at the same time as the phone call is made to the relevant GP surgery, so that the information required can be filled in accurately and to confirm that the phone call has been made.

If the patient notes being used in the ward or department are not the full version at the time of death, the form should still be completed and put in the notes when appropriate.

It is the responsibility of the individual wards and departments to ensure the confirmation of death forms are available on the wards and to ensure it is accessible for the appropriate person to use when informing primary care of a patient death.

The form requires certain information to be completed in order to record the communication with a GP surgery. This information should be completed at the time of a notification phone call being made.

The importance of this information being filled in accurately, legibly and in full is paramount in identifying that primary care has been informed of any deaths in the appropriate way, and within the necessary timescales. This will provide an auditable trail of communication processes should this be needed at any time.

4.2 Telephone notification to relevant GP surgery

The notification of a deceased patient should always be made to the relevant GP surgery as soon as possible, but at least within 48 hours of the incident occurring. Should a death occur out of hours on a Friday night, or over a Bank Holiday weekend where a surgery cannot be informed within the 48 hour period, the patient notes should be retained by the ward or department in charge at the time of death and a phone call **MUST** be made by the first working day. There is, however, no need to hold up the discharge letter process.

When the telephone call is made to the GP surgery, the Confirmation of Death Form should be applied in the notes. The form will display that the patient is deceased and requires some further information to be completed to record the conversation with the relevant surgery. The date and time of death should be recorded for each incident. This will help establish for our records whether the GP should have been informed within 48 hours or if there may have been a slight delay to this due to a weekend or Bank Holiday.

For the purposes of this Policy, In-hours are defined as 08:00am to 17:00pm, Monday – Friday. Out of Hours is defined as any time falling outside of this time period, plus public holidays.

Other information to be completed includes date & time informed GP by phone, within 24 hours - If not the reason recorded, and the person informed at the GP practice and informed by (name of person BHFT) All this information is vital to ensure the Trust is auditable on this process and also to help in any investigation processes that may arise.

4.3 Discharge Letters

It is to be noted that this Policy does not remove the need to issue any discharge letters and that the appropriate documentation should be sent to a patient's GP in accordance with usual practice and within the recommended timescales. All necessary information must be updated within the hospital information systems to ensure electronic records for deceased patients are fully up to date.

Discharge slips/summaries for inpatients should be issued within one day of a patient being discharged, in line with the acute contract and the trust's 'discharge policy'. Staff should also ensure that the patient is discharged correctly as deceased on the system; this will ensure that all future appointments are cancelled and that no further letters are sent out to the family.

4.4 Bereavement Office

It is vital that the information provided on the Confirmation of Death Form is filled in accurately and in full as this will help the Bereavement Office with any subsequent enquiries that are generated as a result of a patient death.

The Bereavement Office will ensure that all sections of the form are complete and accurate. The Bereavement Office will then sign to confirm that all sections of the form are complete ensuring that every step after a patient's death has been followed and then scan this form on V6 under the appropriate patient's record. This will provide an auditable accessible trail.

4.5 Time Scales to Achieve

GP's and other associated support groups, such as community midwives / district nurses or physiotherapists, should be informed of a patient death by telephone **as soon as possible, but no later than 48 hours after the death occurs, or by the first working day following a weekend period – whichever is sooner.**

A Confirmation of Death Form must be completed at the same time as notifying the relevant GP surgery, with details of the patient involved, time and date of death, the cause of death (if this has been verified), the time and date a call was made to the GP, along with recording the department and the *individual names* of whom the conversation took place between. Times recorded should be done so on a 24-hour clock basis.

In the case of an incident occurring out of hours or over public holidays, the patient notes must be retained by the department or ward in charge at the time of death, until such time it is possible to make a telephone call to notify the relevant GP surgery. At this point the Confirmation of Death Form **MUST** be applied to the notes of the patient notes and the relevant information completed in full, making sure to accurately complete the date, time, along with all other required information.

It is recognised that on certain occasions, the doctor in charge of care may require the notes and they will therefore leave the ward / department prior to the first working day after a death. If this is unavoidable, it is the Senior Sister's responsibility to ensure that the correct details are retained within the department to allow the communication with primary care and associated support services to be completed by the first working day. The form should be applied to the notes prior to them leaving the ward, with all possible information filled in and a note beside the within 24 hours question to explain the reasons for not making the phone call. Once the communication has been made, the correspondence information should be recorded and forwarded to the Bereavement Office to allow the information to be updated, fully completed and scanned onto the system.

This Policy has set out the reasons and importance of communicating information to primary care, regarding recently deceased patients and this should be achieved within the timescales set out above.

4.6 Bereavement Midwives

This Policy does not replace the standards for reporting on maternal and paediatric deaths, but must be completed in addition. These forms / checklists must still be adhered to and submitted to the Bereavement Office, as per usual practice.

5. ROLES AND RESPONSIBILITIES

5.1 Divisions

Associate Directors are responsible for ensuring that this Policy is adhered to in relation to all aspects of communication to primary care on deceased patients and also ensure that departmental procedures are in place to follow this Policy. Any areas found not to be complying with this Policy should be the ultimate responsibility of the Associate Director to ensure that this is addressed.

5.2 Senior Sisters

It is the Senior Sister's responsibility to ensure that the mechanisms are in place to allow this Policy to be achieved. A statement within individual employee files should be recorded, preferably within induction checklists for new starters, to show that this Policy has been read and understood. This should be available for any audits upon request.

It is envisaged that the Senior Sister will be responsible for communicating with primary care and completing the Confirmation of death Form; however, this may be carried out by the ward clerk or nurse in charge of a patient at the time of death. In some instances an appropriate colleague where, for example, a death occurs out of hours and there is a change over in the staff on duty would be also acceptable. In this case, it is the responsibility of the Senior Sisters to ensure a sufficient system is in place to allow a smooth handover of patient notes and that communications to primary care are followed up at the earliest opportunity and within the timescales set out in this Policy.

Senior Sisters will also have the responsibility to ensure that any new staff are aware and understand the processes involved, along with the importance of ensuring good working relationships with our partners in primary care.

It is the responsibility of the Senior Sister to ensure that the Confirmation of Death Form is maintained sufficiently and replacements are in place promptly to allow a continuous flow of service.

Replacement forms should be requested through The Print Centre, who will make the necessary arrangements. Forms will be charged to departmental budgets and must be approved by the relevant budget holder.

5.3 Matrons

Matrons will be responsible for validating the procedure in individual wards and departments on an ad-hoc basis, to ensure that the Policy is being followed accurately and sufficient information recorded correctly.

5.4 Doctors Responsibilities

Doctors will be responsible for ensuring an accurate verification of death is recorded on the front page of the form, the responsible consultant should record the cause of death overleaf on the form. This information should be entered as soon as the relevant clinician who is responsible for a particular patient is able to complete this. The clinician will also be responsible for completing the question relating to whether a coroner needs to be requested, or if they have issued a death certificate. The requesting Doctor should ensure they clearly print their name and GMC number in the space provided.

5.5 All Staff

All staff should take responsibility for ensuring they are up to date with the processes involved with communicating to primary care about deceased patients and should know where the relevant policies are held and how to access them.

All staff needs to take personal responsibility for the processes that are set out within this Policy in order to ensure good working partnerships with primary care and maintain a continuous flow of service.

5.6 Maternal Death Co-ordinator

In accordance with the Guideline for the Management of Maternal Deaths, each Trust will have appointed a Maternal Death Co-ordinator who will be responsible for the co-ordinating achievement of actions required following a maternal death. This is normally the Head of Midwifery.

6. FAILURE TO COMPLY

It is important to remember that the reason for this Policy is to enhance the Trust's communications with primary care and improve its working relationships, along with reducing any unnecessary distress for patients' families and carers.

Failure to act upon this Policy and inform primary care about deceased patients in a timely and efficient manner, as set out in this Policy, could potentially be detrimental to the reputation of the Trust and cause very stressful and difficult situations for the family or carers of a patient and any other organisations involved. This could lead to official complaints about the Trust's procedures and if escalated, lead to investigation and scrutiny from a regulatory body.

Any member of staff found to be in breach of this Policy will be subject to further action, in line with Trust policy and procedure.

Any complaints received in relation to this Policy from primary care will be followed up and acted upon accordingly via the corporate team. In addition, it is a requirement for a clinical incident form to be completed where a failure to follow the process as set out in this Policy document has been detected. It will be the responsibility of the individual who discovers the failure to comply, to ensure the matter is raised and a clinical incident form is satisfactorily completed.

7. RELATED DOCUMENTS

This Policy should be considered in conjunction with the following related documents:

- Trust Consent Policy
- Trust Consent Forms for Post Mortem examinations
- Release of bodies from ward / department to the mortuary
- Disciplinary Procedure

8. POLICY EFFECTIVENESS

All staff are responsible for monitoring their own compliance with this Policy. Departmental managers and supervisors should also monitor compliance within their areas on a regular basis and identify any additional training requirements.

The Clinical Coding Office will officially monitor all deceased patient notes for effectiveness of this Policy during their daily discharge coding duties and report on any non-compliance directly to Senior Sisters. All cases of reported non-compliance will be subject to internal audits as and when necessary.

9. POLICY REVIEW

This Policy shall be reviewed every three years or earlier should further information or circumstances occur.

CONFIRMATION OF DEATH	
For Use in Adults & Children	
Date and time.....	HOSPITAL ADDRESSOGRAPH or Surname: First Name: Date of Birth: Hospital Number:
Doctor Name and Designation	
Name.....	
Signature.....	
Grade.....	
Pre-Conditions of Diagnosis	
1. Are you satisfied there is simultaneous apnoea and unconsciousness in the absence of circulation?	Y / N
2. Are you satisfied there is no indication to commence / continue resuscitation? ¹	Y / N
Diagnosis	
3. Have you observed for a minimum of 5 (five) minutes to establish that irreversible cardiorespiratory arrest has occurred? ²	Y / N
4. Is there absence of central pulse on palpation and absence of heart sounds on auscultation?	Y / N
5. In certain hospital settings these criteria can be supplemented by reference to ancillary monitoring modalities: <ul style="list-style-type: none"> • Asystole on continuous ECG display • Absence of pulsatile flow using direct intra-arterial pressure monitoring • Absence of contractile activity using echocardiography If used do these modalities confirm an absence of the circulation?	Y / N / Not used
6. Is there absence of the pupillary response to light?	Y / N
7. Is there an absent corneal reflex?	Y / N
8. Is there an absent motor response when supraorbital pressure is applied?	Y / N
Completion of Diagnosis	
Are you satisfied that death has been confirmed following cardiorespiratory arrest?	Y / N
The time of death is recorded at the time at which these criteria are fulfilled. (Record this in patient record in addition to this form)	Date: Time:
Is there an indication to refer this case to HM Coroner? Please elaborate if yes:	Y / N / Unsure
Is there an indication for a hospital post-mortem examination? Please elaborate if yes:	Y / N / Unsure
All patients can be considered for tissue donation. Check the Organ Donor Register on 01179757580 and Page Tissue Services on 0800 4320559 for further advice.	
Please give the full name(s) of the nurse(s) present at the moment of death?	
Please give the full name of any other person present at the moment of death?	
Did any person present at the time of death express any concern regarding the cause of death?	Y / N / Don't Know

Notes

- Contributory causes to the cardiorespiratory arrest (eg. hypothermia $\leq 34^{\circ}\text{C}$, endocrine, metabolic or biochemical abnormality) should be considered and treated, if appropriate, prior to diagnosing death.
- Any spontaneous return of cardiac or respiratory activity during this period of observation should prompt a further five minutes observation from the next point of cardiorespiratory arrest.

CAUSE OF DEATH: (Responsible consultant to complete)

1a _____
1b _____
1c _____
2 _____

Coroner to be informed: Yes / No:

(ie. Fall, surgery in last 12 months, MRSA, CDiff, industrial cause)

GP INFORMED: (ward clerk or in absence of ward clerk nurse in charge to complete)

Date & time informed GP by phone: _____

Within 48 hours: Yes / No

if No reason: _____

Informed (name of person GP surgery): _____

Informed by (name of person BHFT): _____

DEATH CERTIFICATE COMPLETED: Yes/No

(Any doctor in team who treated patient within last 14 days to complete medical certificate in Bereavement office as soon as possible to avoid delays for family)

Certificate completed by: _____ *signature of doctor*

_____ Print Name

_____ GMC number

Date completed: _____

If spoke to coroner outcome of conversation:
