Doctors CAN verify death!

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Introduction

While completing death certificates and cremation forms, it was noted that documentation of death was not standardised as per the Academy of Medical Royal Colleges guidelines. Additionally, it was noted that documentation of death was placed in the wrong patients' notes. An audit was conducted to formalise these observations. A standardised proforma containing key elements of death verification was created and implemented across the Haematology and Oncology in-patient wards. A second cycle was conducted to evaluate our compliance with national standards, and to make information that is required for filling out cremation forms readily available, so as to reduce delay.

Methods

The standardised proforma was implemented across the Haematology and Oncology in-patient wards in the Queen's Centre. A total of 25 patient records were sampled randomly from the wards and the mortality and morbidity filing cabinet in the doctor's office post intervention.

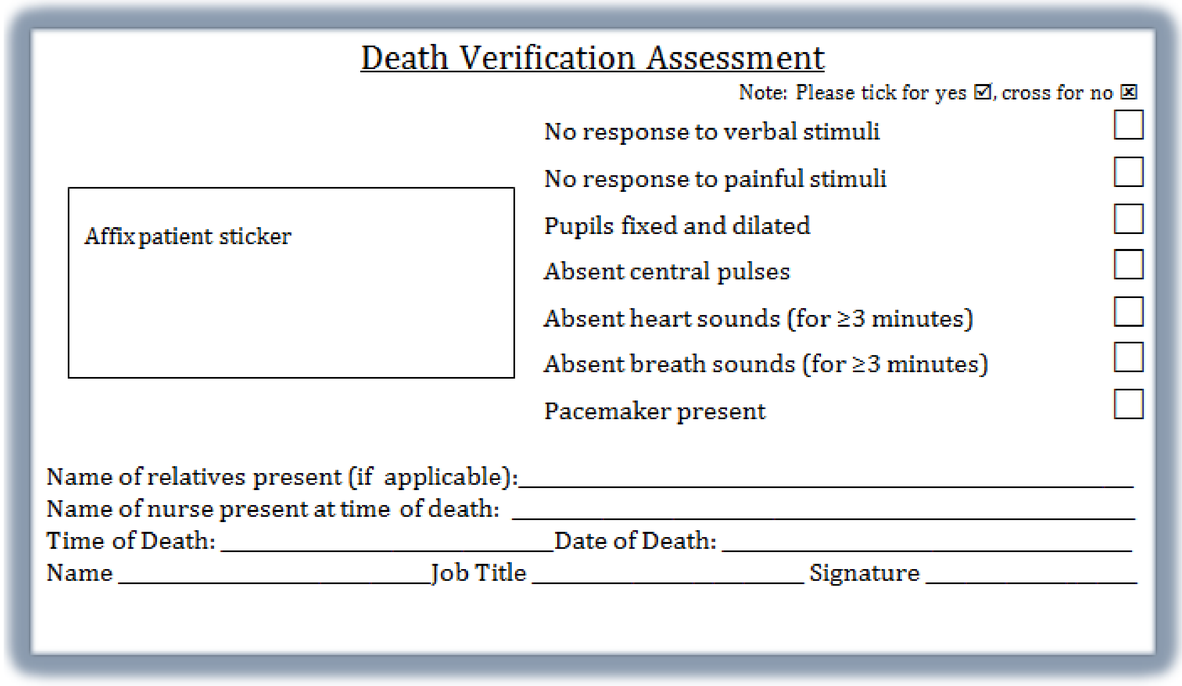
Results

Based on the results, it is evident that the standardised proforma implemented has improved the documentation of Death Verification Assessment. The areas which were poorly documented from the first audit: whether anyone was present at the time of death, names of those present at the time of death, response to voice and absence of central pulses have significantly improved, with 100% compliance to standards.

Discussion

Doctors verify and document death as part of their routine practice, however, the quality of death verification documentation is variable which can result in difficulty in completing Death Certificates and Cremation Forms. With the implementation of our proforma, Death Verification is now documented as per the standards set out by the Academy of Medical Royal Colleges. Furthermore, information that is relevant for filling out Cremation Forms is readily available. Even though this has not been formally evaluated, we perceive this should reduce the time it takes for the bodies of the deceased being released to their loved ones. There is scope for this proforma to be implemented across the Trust.

Standard of death verification	Percentage appropriately documented prior to intervention (%)	Percentage appropriately documented post intervention (%)	Percentage difference (%)
Confirmation of death	80	100	20*
Patient details correctly noted on the page of verification	76	100	24*
Date of assessment	96	100	4
Time of assessment	87	100	13
Time of death	70	100	30**
Whether anyone was present at the time of death	39	100	61**
Names of those present at time of death	0	100	100**
Name of nurse caring for the deceased patient	100	100	0
Whether the patient had a DNAR or RESPECT form in place	96	100	4
Response to voice	48	100	52**
Response to pain	65	100	35**
Whether the pupils were dilated (Or reactive to light)	91	100	9
Absence of heart sounds	91	100	9
Absence of breath sounds	91	100	9
Absence of central pulse	65	100	35**
Presence of a pacemaker	96	100	4
Name of assessor	91	100	9
Signature of assessor	91	100	9
GMC number of assessor	35	100	65**



Death Verification Assessment

Note: Please tick for yes ☑, cross for no ☒

Affix patient sticker

- No response to verbal stimuli ☐
- No response to painful stimuli ☐
- Pupils fixed and dilated ☐
- Absent central pulses ☐
- Absent heart sounds (for ≥3 minutes) ☐
- Absent breath sounds (for ≥3 minutes) ☐
- Pacemaker present ☐

Name of relatives present (if applicable):_____
Name of nurse present at time of death: _____
Time of Death: _____ Date of Death: _____
Name _____ Job Title _____ Signature _____

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