East London
NHS Foundation Trust

GP Support Unit

Standard Operating Procedure

Death Reporting

Version 1.0

Version	1.0
Approved By (sponsor group)	Dr Delroze Miah - GPSU
Ratified By	Quality Assurance Group (QAG)
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Version Control Summary

Version	Date	Author	Comment
1.0	November 2022	Kirsty West & Janice Brazier	Original

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1. Background

The number of patients that are able to die at home is increasing, as support from community staff is effective in allowing patients to be cared for at home or in a nursing or residential home. The practice will therefore generally be notified of the death of a patient via a third party (community staff, relatives, nursing / residential home staff, out-of-hours providers or others, which may include the police or coroner's office).

Effective communication is essential in these circumstances to promptly inform appropriate staff and others involved in the care of the patient to ensure that they are aware of the event, and to avoid causing distress to friends and relatives of the deceased patient.

This standard operating procedure (SOP) should be read in line with the East London NHS Foundation Trust (ELFT) Death Reporting policy.

2. Purpose

This SOP has been written to:

- Ensure all staff are aware of their responsibilities in the death reporting process
- Ensure that the correct contacts are notified in the event of a patient death.

3. Scope

This Standard Operating Procedure (SOP) relates to the following General Practice Support Unit (GPSU) staff groups who are involved in the process of reporting and recording a patient death:

- Patient Records Team (Secretariat)

This SOP does not include clinical actions or processes associated with the death reporting process. Refer to your local clinical procedure for associated clinical processes.

4. Notification of a Patient Death

Deaths are required by law to be registered within 5 days of their occurrence unless there is to be a coroner's post-mortem or an inquest.

Notification of patient death received through a number of communication channels including but not limited to:

- Email
- 111 notification – this will be received as a task through Systmone
- District Nurses in ELFT primary care services who are appropriately trained for verification of death notification
- Family advising the GP (continue with call but await written confirmation)

The patient records team (secretariat) will initiate the requests for the Medical Certificate of Cause of Death (MCCD) to be completed following notification of patient death. The MCCD will be completed by:

- Medical practitioner (Who attended the patient within 28 days before death)
- Or Medical practitioner who attended the patient after death (Including for verification)
- Or Coroner if GP has not seen patient within the last 28 days and there is no other medical practitioner who can complete the MCCD or if patient has recently fallen and had any admissions to hospital. Also check for fractures to be recorded within the coroner's referral

Caldwell Medical Centre (CMC)

Upon notification of a patient death, it is important that all members of staff are informed immediately to minimise any possible distress to members of the family of the deceased through any inappropriate communication.

- The staff member who receives the notification should send a notification to all staff
    - To do this go to notifications tab within Systmone and send a task to all staff advising of patient death (this should include the district nurse team and other appropriate allied community teams involved in care)
- Once the notification has been sent to all staff a separate task should be sent to the patient coordinator team to update the patient record with a note that the patient has passed.
- The "Patient Death Tracker" (Located in J Drive) will also require updating with the below details:
    - NHS number
    - Date of death
    - Environment
    - How the practice was notified?
    - GP that they last visited and the reason for the appointment
    - Who is producing the death certificate – Coroner, hospital, GP
    - Date the letter of condolence was sent to the family

4.Informing Secondary Care Departments

The patient coordinator team must send a letter or email to all secondary care departments that the patient is under the care of to inform them of the patient's death. This can be sent via an action within Systmone.

Updating Records of Next of Kin

After being informed of a patient's death and once the next of kin have been informed the patient coordinator team must add a bereavement alert to the records of any patients listed in the next of kin details. This bereavement alert does not need to be removed and will remain on the patients next of kin record.

The patient record coordinators should also select the letter template to send a letter of condolences to all of the patient's next of kin.

The letter template can be found by navigating to the patient record and selecting "Apply template"

Leighton Road Surgery (LRS)

Upon receipt of a notification of a patient death the patient records coordinator (secretariat) will update the patient record with a note that the patient has passed and send an urgent red flag task to reception management (under task group Death Notice). This is to minimise any possible distress to members of the family of the deceased through any inappropriate communication.

The patient record coordinator (secretariat) is required to complete the patient checklist which details. This is a hardcopy checklist:

- Date of Death
- Next of Kin details
- Individual completing the death certificate
- Where the patient will rest – Note: If the patient is being cremated the patient coordinator team should assign as task to the GP to complete a Medical Certificate (Cremation 4) which will accompany the MCCD when sent to the registrar
- Confirmation that the relevant paperwork has been scanned to correct contacts

The patient record coordinator (secretariat) should also send a task to the last GP who saw the patient advising that a bereavement call should be booked as an appointment.

- On the bereavement call the GP will also request details of the funeral arrangements for capturing on the patient checklist (Cremation or Burial).

If we receive written notification that the patient has passed away in hospital, red flag task reception management details of death – passed away in hospital and patient can then be deducted.

5. Informing the registrar (CMC & LRS)

Once the MCCD is complete – either by the GP or the coroner – a copy must be forwarded to the patient record coordinator team who will follow the below process:

- Send a copy of the MCCD, Next of Kin contact form to the local registry office
- If the patient is being cremated the patient record coordinator team should also attach Medical certificate (Cremation form 4) and email to funeral home
- Phone the patients next of kin to advise that the MCCD has been sent to the registry office.

The patient record coordinator team lead should then follow the deduction process to remove the patient from the practice list.

LRS - The patient coordinator team lead will send a notification to all staff advising of the patient death.

To do this go to notifications tab within Systmone and send a task to all staff advising of patient death, this should include community team members e.g. District Nurse.

6. Review

This policy will be subject to review every three years, or, in light of any changes to National Standards or Trust policy.