**Bereavement administration**

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All patients who die on critical care require the following paperwork to be completed:

1. **Death certificate** or **Electronic coroners’ referal**
2. **Hospital “level 1” mortality form**

Some patients may also require a **Cremation Form.**

Keeping track and ensuring these are all done in a timely fashion requires an organised approach – outlined below:

1. The patient’s death must be **verified** and the time recorded. (see separate death Verification SOP)
2. **Immediately following death a sticker** **and addressograph must be placed on the appropriate page of the desk diary** in the trainee’s office. This sticker will form the “checklist” to make sure that everything has been completed. If you notice that the supply of stickers (kept in the lowest drawer on the desk in the trainee’s office) is running low please ask the A3 North receptionist to print out more.
3. Following death the patient’s **medical notes must all be placed in the large clear box in the trainee’s office.**
4. Trainees **must discuss with the appropriate consultant** before the end of their shift about whether the patient requires a **death certificate or a coroner’s referal**. Best practice is to discuss this at the time palliative care is initated for any patient. At the latest this discussion must take place at the end of shift handover. **Wherever possible the required paperwork should be completed by the team on duty when the patient died.** This is especially important for patients who are admitted and die early as the staff on the next shift may not have seen them. Completing all paperwork while still “on shift” greatly reduces the likelyhood of being called at home about problems.
5. **Death certificates** can be issued once the wording has been agreed with a consultant. The forms are in the big orange books in the trainee’s office. Tear off and place the completed form in the patient’s notes, making sure to complete the “counter stub”. Death certificates can only be issued by a doctor who saw the patient during the last 30 days of their life. If you notice the orange book is getting close to empty please give the cardboard “tear off” to the A3 North receptionist so they can order a replacement before the old one runs out.
6. **Coroner’s referal** – referrals to the coroner are completed electronically and should be emailed from the CC trainee’s generic email account. Indications for and further information on how to do this are covered in the separate SOP for Coroner’s referals. The medical notes for patients referred to the coroner should be kept in the trainees’ office until a decision is received. This is so that a death certificate can be issued immediately if that is the coroner’s decision.
7. **Complete a UHB “level 1” mortality form**. This is a paper form and blank copies are kept in the orange envelope in the trainee’s office. Once completed place it in the medical notes.
8. **Only complete a cremation form if requested**. These are time consuming and must be completed by someone who has seen the patient after death – usually the person who verified the death and issued the death certificate . You should receive a cheque in the internal mail for this work. You will also need to discuss the case with the pathologist who is issuing the second part. They will ask you for another doctor who can corroborate your account. Please be certain that you have checked for the prescence of pacemakers, ICDs or other implants. You do not need to remove them yourself but you MUST make sure that the mortuary know about them.
9. **Make sure that you “tick” everything that has been done on the sticker in the diary and “strike through” the whole thing when everything is completed**.
10. **When all is completed please hand the notes, with the enclosed paperwork, to the A3 North receptionist to check and take to the Beravement office**. Incomplete paperwork will be returned to the doctor. “Out of hours” please leave the notes in the big clear box for the next day’s daily nominated trainee to check.
11. **Role of the “Daily Nominated Trainee for Beravement”.** Each working day one trainee (CT1 or more senior) will have a “star” next to their name on the rota. Their role is to “troubleshoot” any problems with beravement paperwork. This takes priority over all clinical duties except life-threatening emergencies. They should:
    1. **Check the diary and see what has been completed and what is outstanding**
    2. **Check the trainee’s generic email account for any actions and to make sure that all recent coroners referrals have been sent.**
    3. **Liase with appropriate colleagues regarding uncompleted paperwork.**
    4. **Give any completed notes and paperwork to the A3 North receptionist as soon as they are done**
    5. **Be available for any problems from admin staff, coroner, police or beravement office**
    6. **Escalate any problems to the duty consultants in a timely fashion**
    7. **Identify cases for CC M&M**
    8. **Bring any problems to the 1pm “Spotlight” MDT round for discussion**
    9. **Liase with speciality teams when complex diagnoses or medico-legal issues are involved.** It is often appropriate to “hand over” the management of such cases to the speciality “parent” team. (e.g. haematology are very keen to complete the paperwork for their patients with haematological malignancy). Oversight of the “parent” teams should be maintained to ensure that they have completed all of the required paperwork in a timely fashion. The notes should be retained on critical care until all is completed.

**Auditable standards:**

1. **% of deaths registered within 5 calendar days –** target 100% - legal requirement
2. **% of deaths that require coroners referal that are referred** – target 100% - legal requirement
3. **% of deaths that have had a death certificate or coroners referal completed by 1pm on the next working day** – target 100% - unit standard
4. **% of CC patients who have had a “level 1” mortality form completed –** target 100% - Health Board standard