



PATIENT SAFETY TOOL BOX TALKS®

EFFECTIVE CARE & SUPPORT

HEALTHCARE RECORDS DOCUMENTATION REQUIREMENTS FOLLOWING DEATH OF SERVICE USER

v1.1



Definition

Healthcare records are legal documents and are designed to provide an **overview** of the service user's state of health before, during, and after a particular therapy. The healthcare record should contain sufficient information to identify the service user, support the diagnosis, justify treatment, document the treatment course and results and facilitate continuity of care among healthcare providers.

Role of Healthcare Records

The content of the healthcare record provides an accurate chronology of events and all significant consultations, assessments, observations, decisions, interventions and outcomes.

The content of each record complies with clinical guidance provided by professional bodies and legal guidance provided by the Clinical Indemnity Scheme. This standard applies to both hardcopy and electronic documentation. Good record keeping, whether at an individual, team or organisational level, has many important functions. These include a range of clinical, administrative and educational uses such as:

- Helping to improve **accountability**
- Showing how **decisions** related to patient care were made
- **Supporting** the delivery of services
- Supporting effective **clinical judgements** and decisions
- Making **continuity of care** easier
- Providing documentary **evidence of services** delivered
- Promoting **better communication** and sharing of information between members of the multi-professional healthcare team
- Helping to **identify risks**, and enabling early detection of complications
- Supporting **clinical audit, research**, allocation of resources and performance planning helping to **address complaints** or legal processes.



Key Standards & Practices to be included in the contents of Healthcare Records Management regarding the documentation of the death of a person.

Death entry to be included in the content:

- Date and time of confirmed death, details of what examinations were undertaken to confirm death.
- Events leading to the person's death and the cause of death.
- Clear signature, PRINTED NAME, job title, bleep number and registered identification number of the medical practitioner confirming death.
- Final diagnosis, to include principal diagnosis and all procedures.



Death notification contents include - information to be entered on the healthcare record of the deceased:

- If family members or others were present at the time of death
- In the absence of family in attendance at time of death, **if**, how and by whom were the family informed about the death
- Has or will be GP be informed
- Has or will other care services be notified of the death

Care and Documentation after death must include:

- Who provided last offices to the deceased person?
- List of valuables or property within the healthcare setting
- Mortuary transfer documentation
- Part 1 of the Death Notification Form Booklet to be completed
- Cremation medical form if required
- Documentation associated with Hospital Post Mortem Examination or Coroners Post Mortem if required

If the death is reportable to the Coroner, the following information is recorded in the healthcare record:

- The reason why the death is being reported to the coroner
- The name of the person who made the decision to notify the coroner
- The date and time of the notification
- The name of the person who was notified in the coroner's office
- The decision taken by the coroner's office regarding post mortem.

