Death of a Service User Policy

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Category:	Clinical
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Lead Officer:	Director of Nursing
Equality Impact Assessment completed:	Yes

Applicable Legislation/Regulations:
Francis Report 2013 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
Codes of Practice:
MHA 1983 MCA 2005
Purpose:
Within any Hospital setting it is inevitable that there will be instances when deaths of Patients occur. The purpose of this policy and procedure is to ensure that Inmind handles these situations in an appropriate manner. It has established a framework to ensure: • Relatives and carers are informed as soon as possible. • The CQC, Police and Coroner are notified as appropriate and 'without delay'. • Death certificates are appropriately issued. • All required documentation (e.g. Care Quality Commission notifications, Incident forms etc.) are completed 'without delay'. • Any sudden, unexpected or suspicious deaths are investigated. • Any necessary arrangements are made with the Coroner and appropriate funeral directors. • Religious needs are met, and religious strengths are engaged to support recovery. • Other Patients are supported in a timely manner The way staff manage the death of a Patient and how they support relatives is set out in this policy and procedure. The effective management of a death and the support provided to their families is of primary importance and can help all those involved gain resolution and come to terms with their loss in a safe and natural way.

Version Control Table		
Date Ratified	**Version Number**	**Status**
Feb 2018	V1	Closed
Feb 2019	V1.1	Live

Date	Key Revision
16/02/18	Policy revised to incorporate more detail of standards outlined in The Francis Report (2013). Incorporated existing policies (x3).
Feb 2019	Reviewed - No change

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1.0 The Policy

a) In the sad event of a patient dying, the deceased will be accorded the respect and dignity required at this sensitive time. Consideration will be given to the patient's spiritual, cultural and religious wishes, and to any special requests made by the patient and/or their family.

b) In every case of the death of a Patient within in an inpatient setting, the Patient's nearest relative and person with whom they had closest contact should be informed as soon as possible after confirmation of death

c) When the Multidisciplinary Team (MDT) believe that the time of death may be imminent, they must monitor the situation very closely. In the event of a patient with a current 'Do Not Attempt Cardio Pulmonary Resuscitation Order (DNACPR)' suffering a cardiac arrest, the MDT must ensure that death occurs naturally without clinical interference.

d) The senior members of the clinical team, including the on-call Consultant are to be contacted immediately.

e) If there is any doubt about the situation staff have a professional responsibility to follow normal procedures for resuscitation. Where a decision has been made not to resuscitate, this should be recorded in both the patient's records or the designated DNACPR Form and via Inmind incident reporting system.

f) When a Patient is known to be suffering from a terminal illness the clinical team must develop a care plan to cover issues that will arise at time of death and thereafter. Wherever practicable, any decision to withhold lifesaving treatment for a Patient must be incorporated into the care-plan.

g) In addition, and again wherever practicable, any decision to withhold life-saving treatment for a patient lacking capacity to consent to the same must be supported by a Mental Capacity Act (MCA) compliant capacity assessment and best interest checklist assessment.

h) Completion of the best interest checklist assessment will include taking all practicable steps to ensure that there is no valid Advance Decision, Lasting Power of Attorney (LPA) Health and Welfare decision or any Court of Protection decision that prohibits the withholding of life-saving treatment.

i) The death of a patient detained under the Mental Health Act 1983 is regarded as a 'death in state detention' by the coroner. Currently, death in state patient status also applies to those patients who are detained under a Mental Capacity Act Deprivation of Liberty Safeguards (DoLS) order.

j) The coroner also has discretion to consider those patients who are:-

- In general-hospitals whilst continuing to be legally detained under the Mental Health Act 1983.
- In receipt of a Community Treatment Order (CTO).
- Conditionally discharged under Part 3 of the Mental Health Act 1983.

c) Where relevant the Coroner, Police and Care Quality Commission should be notified. Advice should be sought from Inmind Legal Adviser as to how the Coroner is investigating a death in these circumstances.

2.0 The Procedure

2.1 Following the death of a patient

a) When the patient is pronounced dead the following procedure must be followed: Monday to Friday 9am to 5pm - The Registered Manager, The Hospital Director and the Medical Director should be informed immediately

b) Out of hours - the Senior Manager on call should be contacted immediately who will endeavor to get to the hospital in the shortest time possible to support the staff, and contact the above.

c) The local Police Department and the Coroner's Office need to be contacted immediately by the Senior Manager on call or Hospital Director / Registered Manager.

d) The area should be sealed until the police/Coroner indicates otherwise.

e) The patient's bedroom should be sealed and no one should enter without authorization of the Police/Coroner/Registered Manager as appropriate. The police/coroner may wish to remove articles and a list of items removed should be logged where possible. If appropriate copies of documents can be requested and retained.

f) This procedure may change under the direction of the police. Files may be removed, therefore a nominee should be appointed to make copies where possible prior to removal.

2.2 Informing Relevant Others

a) NOK / Relatives should be informed by a member of the senior management team (SMT) preferably in person as soon as possible.

b) The Commissioning Team of the patient should be contacted by the Business Development Department. If the death occurs out of office hours or at the weekend they will be informed as soon as possible by the senior management team.

c) The RC should contact the patient's GP and relevant Gatekeeper

d) The Hospital Director will notify the hospital insurers

2.3 Accessing and Submitting the Documentation

a) All staff on shift that had contact with the patient should document what happened. Guidance should be provided by the NIC, the Clinical Lead or the Senior Management team.

b) The last person to see the patient alive needs to document the patient's physical and mental state at the time they last saw them alive.

c) The Nurse In Charge of the shift and if appropriate the Night Services Co-coordinator will need to write a full report of the shift regarding the patient and their physical / mental state.

d) A Serious Incident form needs to be completed

2.4 Staff De-brief

a) All staff involved should remain on the hospital premises until instructed otherwise by senior management/the police

b) A debrief needs to take place as soon as possible which includes all relevant staff who were on duty. A facilitator could be requested to assist at this debrief.

2.5 Informing the Ward Community

a) The Registered Manager is to inform other patients of the patient's death as soon as appropriate, according to his / her judgment.

2.6 Notifications

a) Central Office should be contacted by the Hospital Director or Registered Manager immediately and a report sent as soon as possible.

b) The Registered manager should contact the local Health Authority responsible for registration within 24 hours and a report sent as soon as possible. The Local Authorities Social Services also need to be informed where the patient was under the age of 18.

c) Regulation 17 (outcome 19) Deaths and unauthorised absences of people who are detained or liable to be detained under the MHA 1983 should be completed if the patient was on a Section of the MHA 1983.

d) The Staff member on duty responsible for the team at the time of the patient's death must ensure that the CQC has been informed (using the appropriate form) 'without delay'.

The term 'without delay' is defined by the CQC as: - "the timescale requirement for a number of notifications. It means exactly what it says – that providers should submit their notification as quickly as possible after the event has happened." (CQC Statutory Regulation No 16).

This replaces previous statutory time limits set by the CQC's predecessor (the Mental Health Act Commission or MHAC) which used to state within 24 hours. It should not be assumed that without delay means that the previous time limit of 24 hours may be exceeded.

e) If the patient was a Restricted Patient the MOJ must be informed and the appropriate clinical reports prepared and forwarded.

f) CQC has the right to come and visit the site immediately if they so wish.

2.7 On Certification of Death

a) As soon as the NIC / Doctor who confirms the death has completed the final entry into the MDT notes these should be sealed along with any other records relating to the deceased in a large envelope and taken to the Registered Manager's office immediately.

b) IT must be notified to immediately gather and seal all of the patient's electronic notes. These must be moved to a nominated secure drive (See sources of data checklist).

c) A subsequent correspondence file must be created by and kept in MHA Office archives, in which all future interactions with people external to the hospital must be documented.

2.8 Reporting

a) As soon as practicable, and once indicated by the police (if required) a nominee needs to be appointed to gather all the patients property, post and belongings into one area and forward to the Registered Manager's office.

b) A Serious Incident Review needs to take place as soon as possible. A further meeting may be required once the hospital receives the Post – mortem results and the cause of death has been established. All relevant persons should be invited and minutes should be taken.

c) All deaths must be reported on an incident form and categorised as Strategic Executive Information Systems reportable adverse incidents (Steis Report). It is the Staff member on duty responsible for the team at the time of the patient's death who must ensure that this is done.

2.9 Funeral Arrangements

a) If the patient has an identified Nearest Relative a member of the SMT needs to maintain contact with the Nearest Relative to ensure effective communication in relation to funeral arrangements and documented in the subsequent correspondence file.

b) If the patient has no identified Nearest Relative all possible acquaintances of the deceased need to be contacted with the assistance of the Social Work department to identify someone who would be prepared to assist with the funeral arrangements.

c) If the patient has no identified Nearest relative a representative of the hospital will need to register the death once the Coroner has issued the results of his investigations. The Coroner will automatically send to the registry office the death certificate. See below details regarding registering a death.

2.10 Funeral Arrangements and Costs

a) If it is established that the patient had no nearest relative and no appropriate persons willing to make arrangements with the hospital for the funeral the hospital may need to make funeral arrangements. Local Funeral Directors should be approached to obtain dates, costings etc.

b) Local appropriate religious leaders should be contacted to assist with any Funeral or memorial service. Fellow patients of the deceased should be appropriately involved in the funeral arrangements / memorial service.

c) The person who arranges the funeral is responsible for paying the final bill and it is important to know where the money for the funeral will come from. The person who died may have taken out a pre-paid funeral plan, paying for their funeral in advance. It is important to check their personal papers to see if they had a plan. If they did, this should cover the whole cost of the funeral.

d) If there is no funeral plan, the cost of the funeral will normally be met out of any money left by the person who had died and, where money has been left, the funeral bill should be paid before any other bills or debts. Even if the person's bank account has been frozen following the death it may be possible to have funds released from a building society or national savings account on showing the death certificate. The person may also have had an insurance policy which will cover funeral costs. In other cases, relatives may need to borrow money until the person's money and property are sorted out. Some funeral directors will allow payment to be delayed until this has happened.

2.11 Patient Property

a) The proper, sensitive and dignified management of the patient's personal possessions is a critical area for consideration to ensure the family are supported at this difficult time.

b) The authority for release of possessions is in the first instance with the police and coroner's office following the death of a detained patient or if a suspicious death has occurred

c) Sensitive liaison with these agencies and the family will be necessary to determine the timescale for release.

d) Any suicide notes or other letters will, in the first instance, be removed by the police for the purpose of their enquiries. Any decision regarding the return of these and other letters will be guided by the police and coroner

e) Once the cause of death has been established and the coroner / police have agreed that the patient's belongings can be removed from their room the belongings should be checked for any letters / correspondence which relate to any final wishes of the deceased or any details regarding a will.

f) The nurse manager is responsible for ensuring that the deceased patients' property is gathered together, inspected for signs of bodily fluids (blood, vomit, etc.) and if these are present those articles should be cleaned or laundered. See sources of patient property checklist.

g) Any patient property must be forwarded on to the executor of the will if applicable, or the nearest relative should be consulted as to their wishes for the property if applicable Following the death of a patient the Mental Health Act Office will establish whether the Finance Office or patient's legal representative is holding a Will. The possessions will then be offered to the family or other interested party for their decision as to retention or disposal. The Finance Department hold the documentation to be completed by the relatives collecting the possessions so should be contacted to provide the appropriate paperwork.

h) The possessions should be dealt with respectfully and placed into containers not black bin bags. For patients who have had a long stay in hospital there will need to be a discussion with the family about accumulated property and their wishes for the return or disposal taken into account.

2.12 <u>Further information about registering the death</u>

a) The registration of the death is the formal record of the death. It is done by the Registrar of Births, Deaths and Marriages and you will find the address of register office in the telephone directory.

b) When someone dies at home, the death should be registered at the registry office for the district where they lived. If the death took place in hospital or in a nursing home it must be registered at the registry office for the district in which the hospital or home is situated. Registry offices usually have an appointments system so should therefore be contacted by phone to make arrangements for the death to be registered.

c) A death should be registered within five days but registration can be delayed for another nine days if the registrar is told that a medical certificate has been issued. If the death has been reported to the coroner you cannot register it until the coroner's investigations are finished.

d) It is a criminal offence not to register a death. The death should be registered by one of the following (in order of priority):
- a relative who was present at the death.
- a relative present during the person's last illness.
- a relative living in the district where the death took place.
- anyone else present at the death.
- an owner or occupier of the building where the death took place and who was aware of the death.
- the person arranging the funeral (but not the funeral director).
- You cannot delegate responsibility for registering the death to anyone else.

e) You must take with you the medical certificate of death, since the death cannot be registered until the registrar has seen this. If possible, you should also take the person's NHS medical card and birth and marriage certificates. The registrar will want from you the following information:

- date and place of death.
- the full name of the person (including maiden name) and their last address.
- the person's date and place of birth.
- the person's occupation and, in the case of a woman who was married or widowed, full name and occupation of her husband.
- if the person was still married, the date of birth of their husband or wife.
- whether the person was receiving a pension or other social security benefits.

f) Forms: When you have registered the death, the registrar will give you a green certificate (for which there is no charge) to give to the funeral director. This allows either burial or cremation to go ahead. Occasionally a registrar may be able to issue a certificate for burial only (but never cremation) where no one has yet been able to register the death.

g) The registrar will also give you a form to send to the Department for Work and Pensions (DWP) (In Northern Ireland the Social Security Agency). This allows them to deal with the person's pension and other benefits.

h) Death Certificate: The death certificate is a copy of the entry made by the registrar in the death register. This certificate is needed to deal with money or property left by the person who has died, including dealing with the will. You may need several copies of the certificate, for which there will be a charge.

2.13 Support - Special Faith needs of the Dying/Dead Person

a) Inmind recognises that the people it cares for will come from a variety of cultures and ethnic backgrounds. When a person is dying or has died there may be specific rights and rituals which need to be undertaken in accordance with their personal belief system.

b) Some of these needs may have been identified in an advanced statement or be known by members of their family

2.14 Support and Counselling

a) If a patient has died unexpectedly we will offer professional counselling and support for the friends/ relatives of the bereaved. When contact is made with the family this support can be offered if appropriate.

b) If a patient has died unexpectedly we will offer professional counselling and support for the staff involved with the patient.

2.15 **Media Interest**

a) Any media interest shall be directed to the Communications Department who will not release any information about the event unless and until this has been agreed by the patients' next of kin or unless the circumstances make immediate comment imperative.

Appendix 1

Equality Impact Assessment for this policy

Protected Characteristic (domain)	Area of conflict	Resolution
Age	Nil	N/A
Disability	Nil	N/A
Gender Reassignment	Nil	N/A
Pregnancy & Maternity	Nil	N/A
Race	Nil	N/A
Religion or Belief	Nil	N/A
Sex	Nil	N/A
Sexual Orientation	Nil	N/A
Marriage and Civil Partnership	Nil	N/A

All relevant persons are required to comply with this policy and must demonstrate sensitivity and competence in relation to diversity in race, faith, age, gender, disability and sexual orientation. If you feel you are disadvantaged by this policy, please contact the Registered Manager and the service will actively respond to the enquiry.

Sources of Patient Data Checklist
All staff should contact IT should they have any files stored in any location for IT to remove and seal. Regardless, IT will check the following. This list is not exhaustive.

1. Patient Files including:

Care Plans
CPA
SAVRY
CAN(for)
MANCAS
START
Star Risk
Risk Management Plans
PCL-SV
RSVP
SAPRoF
HCR-20
OT
Psychology
Social Work
Physical Health
Speech Therapy
MHRT Reports
Ward Round Minutes
Patient Ward Round Summary
Patient Liaison Reports

2. Global drives including:

Ward Clinical Lead
Ward Consultant
Ward Education
Ward Medical Secretary
Ward Occupational Therapy
Ward Psychologist
Ward Registered Nurse
Ward Senior Support Worker
Ward Social Worker
Ward Speech Therapist
Ward Team Leader

3. Ward Drives
4. Clinical Drives including:

Contracts Compliance, CPA, Medical Secretaries, MHA, Physical Healthcare, Staff Coordinator and Therapies (including Gym, Nurse Therapy, Occupational Therapy, Patient Liaison, Psychology, Social Work, Therapeutic Services, Therapy PA and Vocational Therapy drives.

5. Non-Clinical Drives including:

Audit, Business Development, Catering, Communication, Education, Estates, Facilities, Finance, Hospital Management (including Assistant Hospital Director, Hospital Director, Hospital Director PA, Registered Manager, Registered Manager PA), Human Resources, IT, Reception, e-MDS, Security, Security Control, Senior Management, Shop and Training drives.

6. Physical Healthcare Database
7. Scanned Documents Drive
8. Home Drive
9. Group-Wide Drive
10. Site-Wide Drive
11. Shared Drives

Sources of Patient Property Checklist
Property and belongings

1. Kitchen (Fridge)
2. Kitchen (Drawers)
3. Bedroom (including security cupboard)
4. Security Storage Room
5. Office (Safe)
6. Finance Department
7. Off Site Storage

Mail

1. Reception
2. Ward offices
3. Patient bedrooms

NOTE: All staff involved should remain on the hospital premises until instructed otherwise by senior management or the police.

Unexpected Death Procedure Flow Chart

Member of staff discovers unexpected

Commence CPR

Call for an Ambulance

Continue CPR until instructed to stop by a Responsible Clinician, Senior Manager or Paramedic

If death is pronounced

Commence 'Who to Contact in the Event of an Unexpected Death Flow

Seal the area until instructed otherwise by the police

All staff on shift who had contact with the patient document what happened

Last person to see patient alive documents physical/mental state on last

NIC/Service Co-ordinator write full report of the shift and patients physical/mental state

Complete a Serious Untoward Incident form

A debrief needs to take place as soon as possible

Following final MDT entry seal note in envelope and convey to the Hospital Director's office immediately

IT to seal electronic documents (follow source of data checklist)

MHA Office to create post death correspondence file to be kept in archives

When indicated by police appoint a nominee to collect all patient property, post and belongings (follow sources of patient property checklist)

A Serious Incident Review held as soon as possible.