Verifying death, implementing a successful change in practice: A completed audit cycle.

Background

In 2008 the Academy of Medical Royal Colleges’ (ARMC) published: A Code of Practice for the Diagnosis and Confirmation of Death, the first guidance for medical professionals in the physiological assessment and documentation required to achieve good practice following irreversible cardiorespiratory death. The recent publication of these guidelines suggested a lack of training in the majority of medical practitioners and as such our audit was designed to test this hypothesis. To develop the audit criteria I also called upon the more practical local trust guidelines for registered nurses verifying death and the GMC’s good practice guidance for maintaining clear, accurate and legible documentation.

Objectives:

- To audit compliance around verification of death against the aforementioned guidelines.

Improve standards of care after death by improving the quality of documentation and assessment process as a whole.

Implementation of a change in practice

Combining standards recommended by the ARMC and our Hospital Trusts existing policy on verification of death for registered nurses 7 Criteria selected

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Standard</th>
<th>Baseline Audit %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pupils fixed and non-reactive to light [1,2]</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Absence of heart sounds for at least 1 minute [1,2]</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Absence of central pulse on palpation for at least 1 minute [1,2]</td>
<td>100%</td>
<td>64%</td>
</tr>
<tr>
<td>Absence of breath sounds for at least 1 minute [2]</td>
<td>100%</td>
<td>70%</td>
</tr>
<tr>
<td>Time of death recorded [1,2]</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Time of verification [2]</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Documentation dated, with name signed and printed clearly by person verifying death[1,3]</td>
<td>100%</td>
<td>68%</td>
</tr>
</tbody>
</table>

Medical notes of all inpatients who had died over a 2 week period. Assessing current practice against the 7 criterion.

46 set of notes audited.

Only 20% of notes reviewed achieved all 7 criteria.

Need for change: Pro forma designed and implemented

Over 95% compliance in all 7 criteria, with 94% of all records fully compliant with standards.

Conclusion:

We have also shown that, whilst pro formas in current hospital practice are becoming somewhat endemic, when used with the correct guidelines and circumstances they can be incredibly effective. This was shown with the dramatic increase in compliance from 20% to 94% at re-audit using this one intervention. Completing our audit cycle has engendered a change in clinical practice to mitigate the potential for error when it comes to the process of verification of death. This in turn will hopefully reduce any undue distress to those close to the deceased along with avoiding any mistakes that could have significant legal consequences.

References:

Acknowledgements:

Dr David Barkley (Consultant in Palliative Medicine) & Louise Brudbury (Specialist Palliative Care Nurse) - assisted in Pro forma development
Dr Stuart Bruce (Consultant Physician) - oversaw audit process
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Setting standards

Baseline Audit

Deficiencies in practice identified

Re-audit

Continued development

Further areas for improvement:

Discrepancies in time of death as noted by ward staff versus the time of death verification infers a lack of knowledge surrounding these definitions. To remedy this teaching has been provided for existing members of nursing and medical staff and has also been introduced at departmental inductions. Further audit cycles are planned to monitor compliance.

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