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Healthcare Improvement Scotland | DCRS Death Certification Review Service

NHS Education for Scotland

Death Certification – getting it right
An innovative educational approach

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Description

The introduction in 2015 of the Death Certification Review Service (DCRS) and a revised medical certificate of cause of death (MCCD) presented doctors across Scotland with new learning needs. This novel scrutiny service, the first of its kind in the UK, falls under the remit of Healthcare Improvement Scotland. The DCRS identified a number of common themes in the errors that certifying doctors made when completing the certificates and worked in partnership with NHS Education for Scotland (NES) to develop a new learning resource to improve accuracy.

Aims and objectives

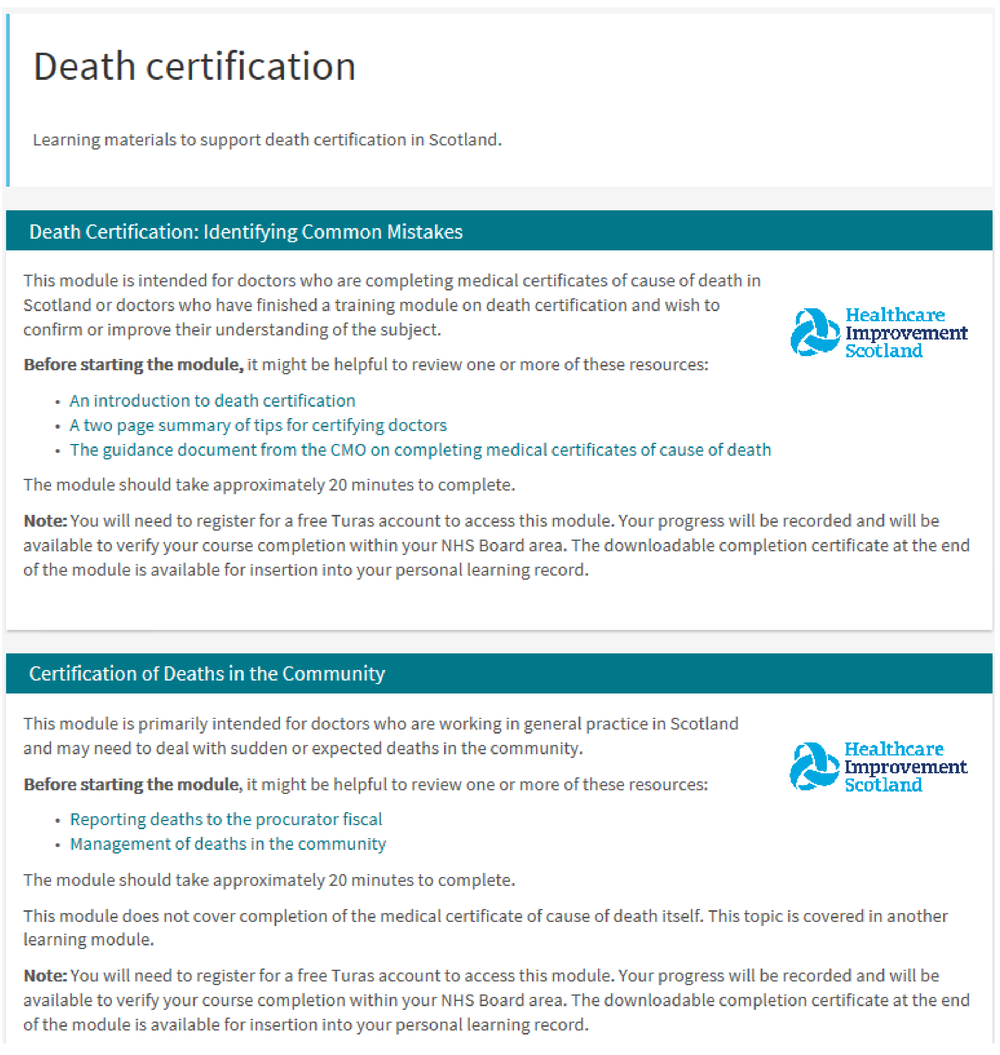
The overall aim of the DCRS is to ensure that death certification is person centred, safe and completed accurately.

Our objective was to produce a supportive and relevant resource which would quickly identify good practice in completing MCCDs.

The module lays out the logical steps in the process of MCCD completion for the learner. As a short module using real-life anonymised examples, it engages the learner and minimises time away from clinical practice to enable completion.

Methodology

- MCCD completion errors were reviewed over the first year of the service to establish which types of errors were most commonly made. This information was then used as the basis to guide our educational approach.
- A series of clinical scenarios with sample MCCDs demonstrating these errors was created and incorporated into a web-based learning module.
- In June 2017, the module was hosted on Turas and widely advertised to territorial NHS boards and doctors at the point when their MCCDs were selected for review.



Death certification

Learning materials to support death certification in Scotland.

Death Certification: Identifying Common Mistakes

This module is intended for doctors who are completing medical certificates of cause of death in Scotland or doctors who have finished a training module on death certification and wish to confirm or improve their understanding of the subject.

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Before starting the module, it might be helpful to review one or more of these resources:

- An introduction to death certification
- A two page summary of tips for certifying doctors
- The guidance document from the CMO on completing medical certificates of cause of death

The module should take approximately 20 minutes to complete.

Note: You will need to register for a free Turas account to access this module. Your progress will be recorded and will be available to verify your course completion within your NHS Board area. The downloadable completion certificate at the end of the module is available for insertion into your personal learning record.

Certification of Deaths in the Community

This module is primarily intended for doctors who are working in general practice in Scotland and may need to deal with sudden or expected deaths in the community.

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Before starting the module, it might be helpful to review one or more of these resources:

- Reporting deaths to the procurator fiscal
- Management of deaths in the community

The module should take approximately 20 minutes to complete.

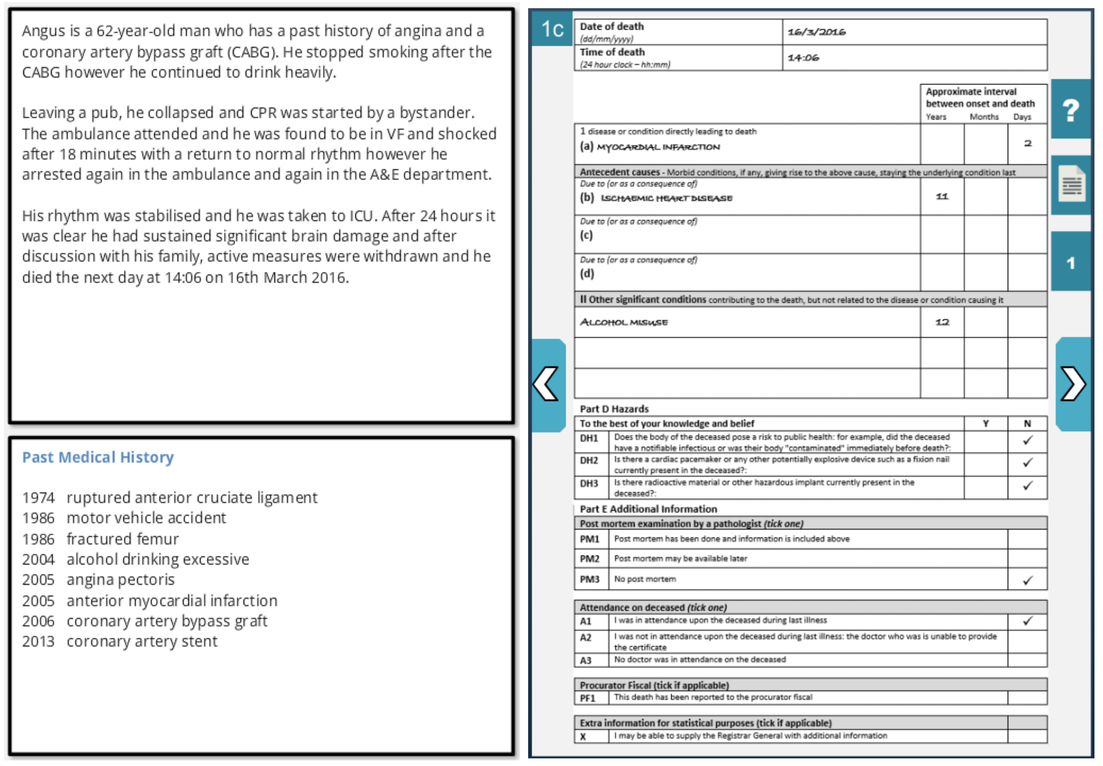
This module does not cover completion of the medical certificate of cause of death itself. This topic is covered in another learning module.

Note: You will need to register for a free Turas account to access this module. Your progress will be recorded and will be available to verify your course completion within your NHS Board area. The downloadable completion certificate at the end of the module is available for insertion into your personal learning record.

Landing page for both the current modules

Outcomes

- The module was reviewed by medical directors or their representatives in all the NHS boards and across hospitals and primary care before release and their comments were used to improve the module.
- It has been well received with a lot of positive feedback and has now been viewed by over 590 doctors.
- Following suggestions from some GP colleagues, another module was developed around management of sudden death in the community (released in January 2018). This module is aimed mainly at primary care and has been viewed by over 185 doctors.
- Building on the success of both, a third educational module is now in production to assist doctors as they complete a certificate electronically.
- The modules are also available on www.sad.scot.nhs.uk which is a NES website dedicated to support healthcare staff who are working with patients, carers and families before, at, and after death.



Angus is a 62-year-old man who has a past history of angina and a coronary artery bypass graft (CABG). He stopped smoking after the CABG however he continued to drink heavily.

Leaving a pub, he collapsed and CPR was started by a bystander. The ambulance attended and he was found to be in VF and shocked after 18 minutes with a return to normal rhythm however he arrested again in the ambulance and again in the A&E department.

His rhythm was stabilised and he was taken to ICU. After 24 hours it was clear he had sustained significant brain damage and after discussion with his family, active measures were withdrawn and he died the next day at 14:06 on 16th March 2016.

Past Medical History

1974 ruptured anterior cruciate ligament
1986 motor vehicle accident
1986 fractured femur
2004 alcohol drinking excessive
2005 angina pectoris
2005 anterior myocardial infarction
2006 coronary artery bypass graft
2013 coronary artery stent

1c

Date of death (dd/mm/yyyy)	16/3/2016
Time of death (24 hour clock – hh:mm)	14:06

	Approximate interval between onset and death: Years	Months	Days
1 disease or condition directly leading to death (a) MYOCARDIAL INFARCTION			2
Antecedent causes - Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last			
Due to (or as a consequence of) (b) ISCHAEMIC HEART DISEASE	11		
Due to (or as a consequence of) (c)			
Due to (or as a consequence of) (d)			
II Other significant conditions contributing to the death, but not related to the disease or condition causing it			
ALCOHOL MISUSE	12		

Part D Hazards

To the best of your knowledge and belief		Y	N
DH1	Does the body of the deceased pose a risk to public health: for example, did the deceased have a notifiable infectious or was their body "contaminated" immediately before death?:		✓
DH2	Is there a cardiac pacemaker or any other potentially explosive device such as a fixion nail currently present in the deceased?:		✓
DH3	Is there radioactive material or other hazardous implant currently present in the deceased?:		✓

Part E Additional Information

Post mortem examination by a pathologist (tick one)		
PM1	Post mortem has been done and information is included above	
PM2	Post mortem may be available later	
PM3	No post mortem	✓

Attendance on deceased (tick one)		
A1	I was in attendance upon the deceased during last illness	✓
A2	I was not in attendance upon the deceased during last illness: the doctor who was is unable to provide the certificate	
A3	No doctor was in attendance on the deceased	

Procurator Fiscal (tick if applicable)		
PF1	This death has been reported to the procurator fiscal	

Extra information for statistical purposes (tick if applicable)		
X	I may be able to supply the Registrar General with additional information	

Screen shots from the "Identifying common mistakes" module

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