



Singapore Healthcare  
Management 2019

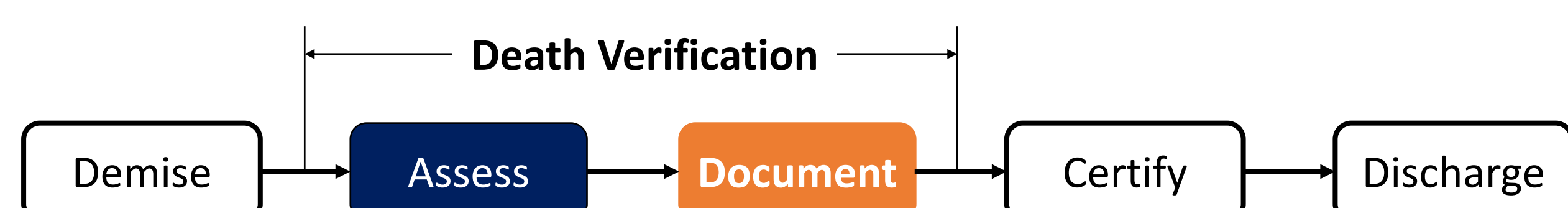
# Improvement of Death Verification Process to Meet Regulatory Requirements

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## Background

Death verification is a clinical assessment process undertaken to establish that a person has died. Its documentation is an important component of this process and is one of the regulatory requirements for complete clinical documentation. However, an audit has revealed multiple incomplete clinical documentation of patient death verification. Based on enterprise risk management tool, this risk was re-assessed to have moderate consequence with probable (likely) occurrence, which is a high risk rating. As further assessment of current risk controls were then deemed inadequate, the department embarked on developing several improvement strategies for ensuring complete documentation of patient death verification.

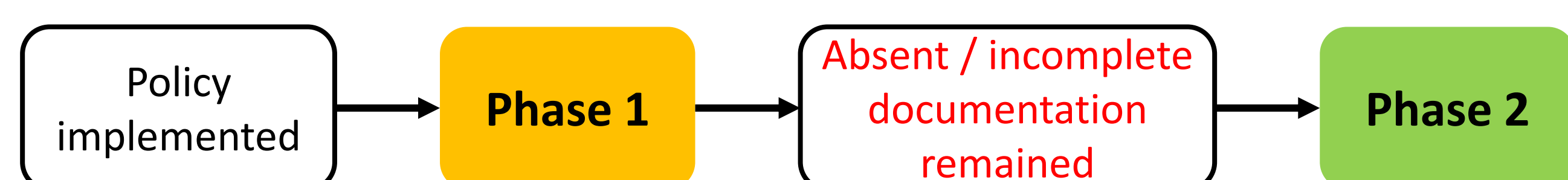
(Note: Incomplete death verification documentation refers to the documentation without date of death, time of death or cause of death.)



## Methodology

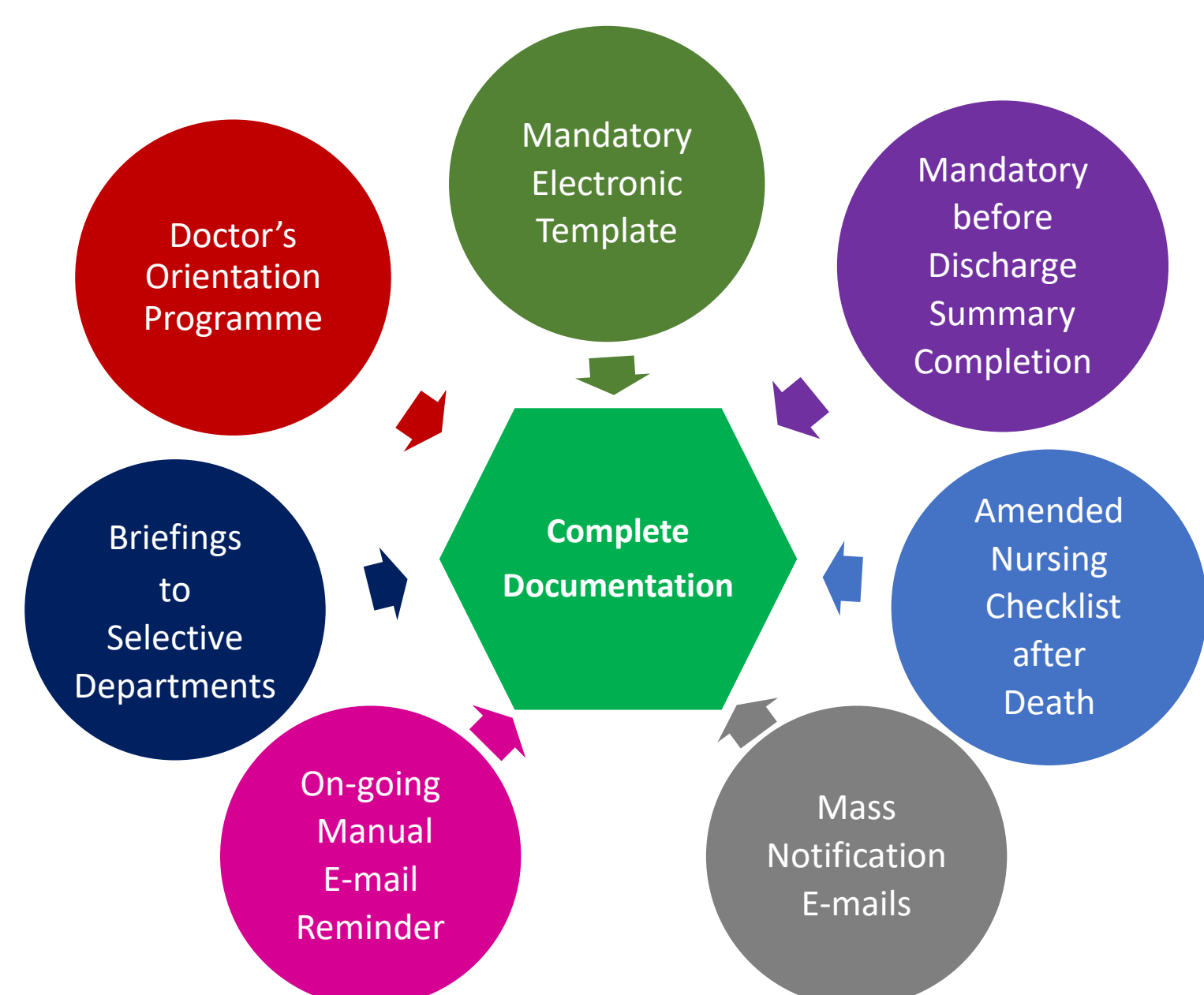
### Phase 1: Audit post policy implementation

Patient Safety and Clinical Standards Unit (PSCSU), Singapore General Hospital (SGH), developed a policy on March 2017 for verification of adult cardiorespiratory death to standardize its process. The subsequent 6 months of audit results highlighted both absent and incomplete documentation still persists. Hence, the department proceeded for more improvement strategies in Phase 2.



### Phase 2: Audit post death verification template implementation and E-mail reminders

An electronic documentation template of patient death verification was developed in March 2018 which is made mandatory for all mortality cases before completion of their discharge summary. To further reinforce the death verification process, mass e-mail notice was sent once to doctors who were attached in SGH. Concurrently, manual e-mail reminders were also sent to those who did not document or use the template after verification of death. Short briefings on the process and use of template were provided to departments with higher episodes of failed documentation and use of the template. In addition, both the verification process and template have been included since the beginning of 2019 in the doctors' orientation programme to increase awareness of this regulatory compliance practice.

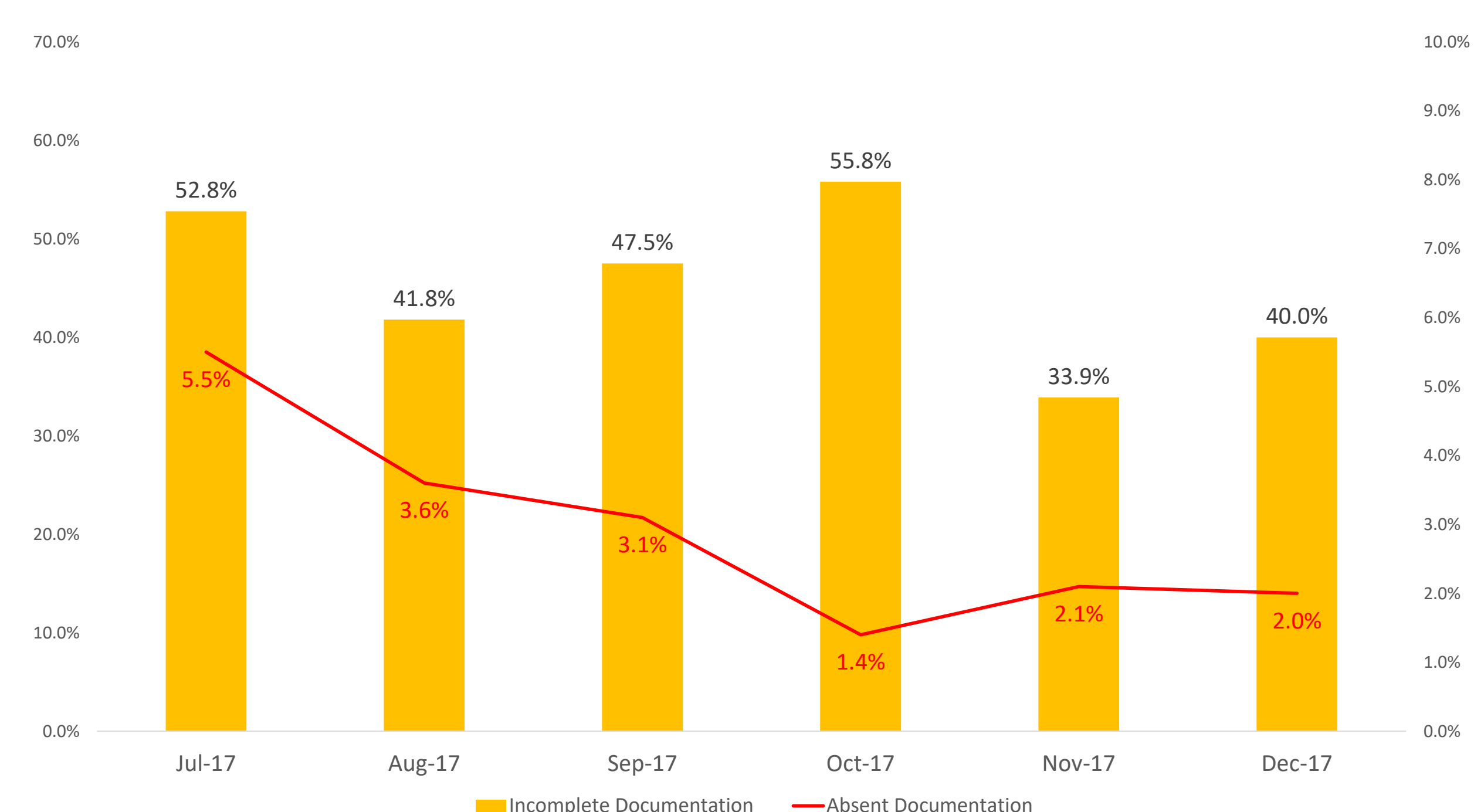


## Results

In summary, complete documentation of death verification was enhanced from **41.7%** in July 2017 to **100%** in April 2019 to meet the regulatory requirements.

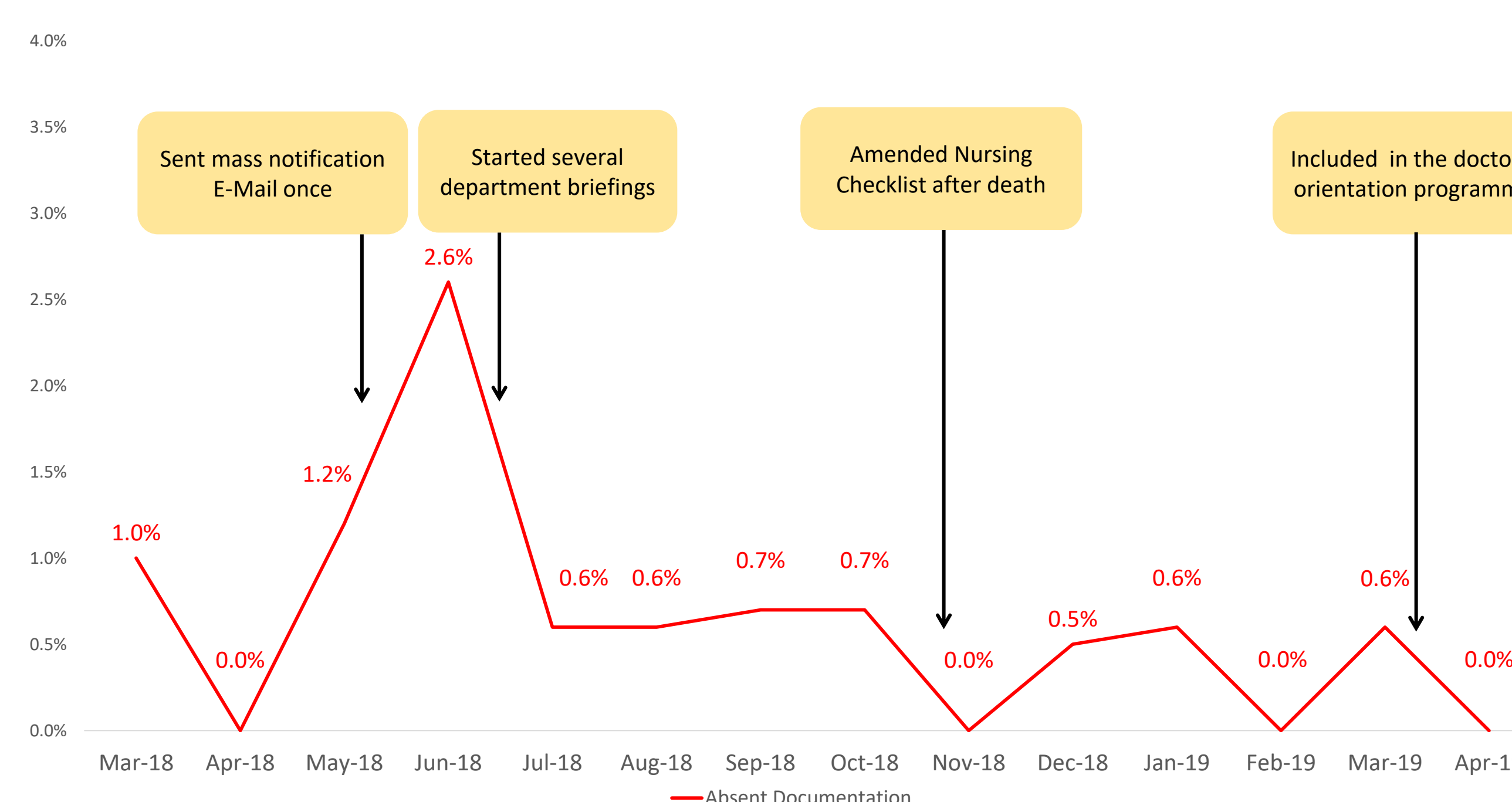
### Phase 1 result (July 2017 – December 2017)

Monthly audit results showed that the percentage of absent documentations decreased from 5.5% to 2% of monthly mortality cases within the audit period. The incomplete documentations declined from 52.8% to 40%. In short, percentage of complete death verification documentation was improved from **41.7%** to **58%** in this follow-up period.



### Phase 2 result (March 2018 – April 2019)

Retrospective audit was conducted within 4 days post discharge. Audit results likewise demonstrated the percentage of absent documentation decreased from 1% to 0% of monthly mortality cases within the audit period. There was no incomplete documentation as the mandatory electronic documentation template includes required assessment elements of death verification. In short, **100%** of death verification documentation was achieved in this period.



## Conclusion

Death verification is an important part of care after death as per regulatory requirements. The development of standardized process for death verification and its incorporation into the discharge process not only improves the operational efficiency but also mitigates the risk of regulatory non-compliance to death verification.