# Learning from deaths: Embedding education in the process of certification of death during the local rollout of the Medical Examiner's service.

A Nelmes, S Goodison, R Montieth, R Morse. University Hospital Wales

British Geriatrics Society
Improving healthcare for older people

The introduction of the Medical Examiner (ME) service has changed the process for Medical Certificate of Cause of Death (MCCD) completion across the UK. Each and every death now receives scrutiny from either the medical examiner service or coroners service, and this requires communication between the certifying doctor and this service. Often, certification of death has been left to the most junior members of the team, sometimes without the clinician in charge of the patient's cares oversight. We saw this as an opportunity for local process redesign and **embedding of team-based education and reflective practice.** We aimed to develop the idea that **the episode of care is incomplete until the communication with the ME service and issue of MCCD is complete.**

## Our approach

In discussion with key stakeholders (ward teams, bereavement staff and the ME Office) we produced a process map of the current after-death care pathway (Fig A), which highlighted communication between stakeholders as a key issue. We developed a team–based Proposed Cause of Death (PCD) form to prompt and stimulate **medical team discussion and reflection.**

**The purpose was threefold -**

**1) To discuss what happened to the patient and identify and formulate a clear and registerable cause of death**

**2) To ensure a senior clinician's input into cause of death discussion**

**3) To communicate clearly the proposed cause of death to the medical examiner in a way that may avoid the need for further phone communication with the team and reduce delays in MCCD completion.**

The form included names and contact numbers of doctors that would be available to certify death to further reduce delays in certification of death post-ME review. This form formed part of a new process where a ward team discussion was key (Fig B).

This was piloted (paper form) on 2 wards (A&B) in 2022, followed by a further 3 wards (C,D&E) in electronic form in 2023. We collected data on numbers of deaths, forms completed and time between death and MCCD completion. Feedback sought from teams, bereavement, and the ME service regarding usefulness and useability of the intervention.

*Team discussion of cause of death presents a **valuable learning opportunity**. This should be the final entry into the patients notes, closing the final episode of care with **whole team involvement**.*

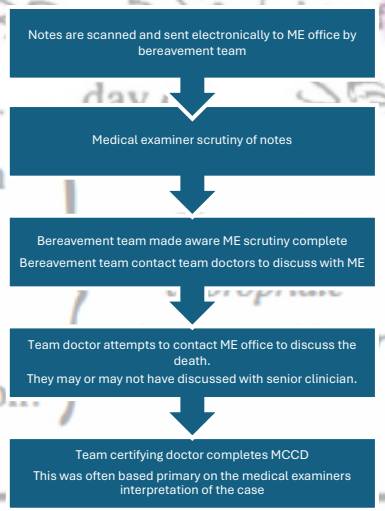


Figure A. Original (control) process map. Mean time to MCCD completion 5.1 days

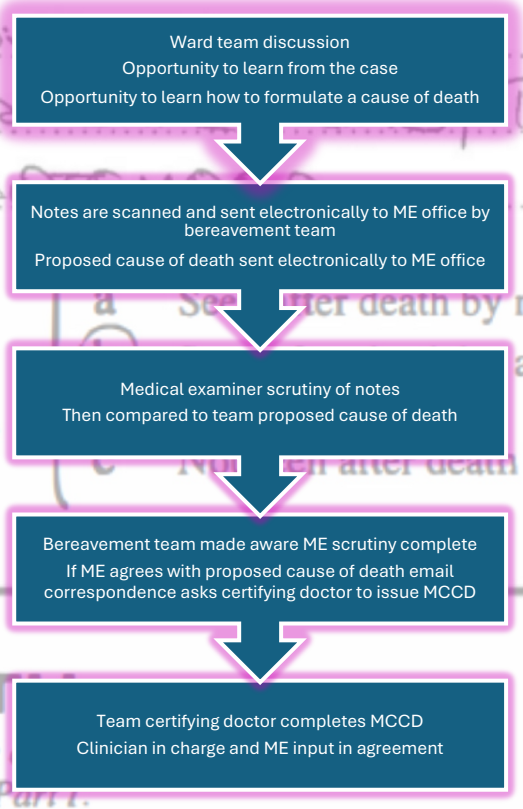


Figure A. New process map. Mean time to MCCD completion 5.7 days

## Our results

The process was **successfully adopted on 2 of the 5 pilot wards**. Feedback from adopting teams commented particularly on the **educational opportunities. The bereavement team commented on improved communication between the ward team and bereavement team**.

Pilot 1: Mar-Aug 2022. Proportion of deaths with form completed: Ward A 0% (0/25), Ward B 71% (27/38). Time from death to MCCD completion was not increased by form implementation (3.1 days after vs 4.7 days before). Pilot 2: Aug 2023–Jan 2024. Proportion of deaths with form completed: Ward C 60.9% (14/23), Ward D 0% (0/22), Ward E 5.3% (1/19). Time from death to MCCD completion increased by only 0.6 days compared to 3 control wards (5.7days vs 5.1days).

## What is gained from adopting this process:

- **improved team ownership of formulation of cause of death decisions**
- **patient management learning through reflection**
- **Improved communication with the ME**
- **Improved communication with and accessibility to bereavement teams**.

This can be done **without increasing time to MCCD completion**.

**Requirements for success:**

1) **ward level consultant engagement, including educational element**
2) **availability of notes**
3) **prompting of the medical team by the bereavement team.**

*Contact email: angela.nelmes@wales.nhs.uk*