SESLHD PROCEDURE COVER SHEET

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KEY TERMS	Notification of death, deceased patient, patient registration, PAS (Patient Administration System), iPM (iPatient Manager)
SUMMARY	This document provides guidance on the process of recording the death of a non-inpatient in the Patient Administration System (iPM)

Feedback about this document can be sent to SESLHD-Policy@health.nsw.gov.au

Notification of Death of Non-inpatients from External Source

SESLHDPR/216

1. POLICY STATEMENT

This document provides instruction on recording the death of non-inpatients in the Patient Administration System (iPM).

2. BACKGROUND

All public hospitals are required to record inpatient admissions, outpatient attendances and other presentation to the Hospital and Community Health Service. This includes information such as diagnoses, operations and mode of separation for inpatients (i.e. discharge own risk/on leave, transfer to nursing home/other hospital/psychiatric hospital, death with and without autopsy). In accordance with this, date, time and place of death are also a standard client registration data element. The reporting and recording of death in the Patient Administration System is imperative for storage of records, accurate patient information and the end-dating of patient appointments, waitlist entries etc. It is line with section 3.5 of the NSW Health Client Registration Policy (PD2007_094).

Notification of deaths are received from a number of sources including:

- Family members/GPs notify the medical record department
- Family member/s notify Outpatient clinics
- Family member/s / GP notify Community health

The key principles prior to entering a Date of Death (DOD) into the PAS application are as follows:

- The correct person is identified (which includes family name, first name, gender, DOB, Medicare etc.) to ensure the correct patient is being deceased
- The information has been obtained from a verified source
- The authenticity of the source is verified

Note: Verbal notification is adequate; written notification is not necessary unless offered by the family member / caller.

Note: Notification via newspaper death notices or other informal sources are not acceptable.

There is no time limit on notification and recording of deaths. All deceased patients who are registered in the PAS should be recorded as such in the PAS, regardless of the date of last presentation, place of death or if there is a delay in the notification process (i.e. patient died many years ago).

3. PROCEDURE

3.1 Notification received by Medical Record Department from family member or external facility:

3.1.1. Notification is to be made to the designated officer (to be determined at each site) in Medical Record / Clinical Information service

3.1.2. Information to be obtained and recorded in the PAS:

- Date of death
- Time of death

- Place of death
- Family member name / relationship of person making notification

3.2 Notification received by Medical Record Department from services within the LHD eg, Outpatient / Community Health

3.2.1. Notification is to be made to the designated officer (to be determined at each site) in Medical Record / Clinical Information service.

3.2.2. Information to be obtained and recorded in the PAS:

- Date of death
- Time of death
- Place of death
- Staff member name who received the notification

3.3. Procedure in the PAS:

3.3.1. Search for patient in iPM (ensuring the correct patient is identified)

3.3.2. Right mouse button click on patient and select 'Patient details'

3.3.3. In the 'Deceased' tab, complete the following fields:

- Tick the 'Deceased" box ensuring a black tick appears
- Enter the date and time of death
- Enter the date and time the death was notified
- Select the place of death
- Enter the following comments: Name of person who notified the death and any other relevant information given by the person notifying the death.

4. DOCUMENTATION

Not Required

5. AUDIT

Not Required

6. REFERENCES

- NSW Health Guideline GL2007_024 – Client Registration Guideline
- NSW Health Policy Directive PD2004_094 – Client Registration Policy

7. REVISION AND APPROVAL HISTORY

Date	Revision No.	Author and Approval
August 2012	1	SES/IS LHD Health Records Committee
December 2012	1	Approved by SESLHD Clinical and Quality Council
August 2015	2	SES/IS PAS UI Reference Group
Sept 2015	2	Endorsed by Executive Sponsor

March 2019	3	Executive Sponsor updated to Medical Executive Director. Medical Executive Director reviewed procedure with minor changes.
March 2022	4	Minor revision by the PAS / UI User Group and Health Records Committee: hyperlinks updated
April 2022	4	Endorsed by Executive Sponsor