The Standard

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ORGAN AND TISSUE DONATION

The Human Tissue Act was amended to *The Human Tissue Gift Act* in June 2004. The revised legislation requires hospitals and any other facilities that may be designated by regulation in the future to notify a human tissue gift agency when a patient dies, when a physician determines that death is imminent and inevitable, or when the facility receives a dead body. The physician or RN should call Winnipeg Health Sciences Centre paging at 787-2071 and ask for the "transplant coordinator on call'. The coordinator will then make a determination of organ (and tissue) donor eligibility and will facilitate arrangements for transporting the patient to Winnipeg so that the organs and tissues can be recovered.

The Human Tissue Gift Act requires anyone who is asked by a HTGA to provide information in respect of a deceased or dying individual, including personal information and personal health information, to do so.

Because when and how to approach next of kin can have a significant impact on obtaining consent, and because donor eligibility criteria changes from time to time, the Eye Bank and Tissue Bank Manitoba ask that physicians and RNs not approach families regarding donation unless asked to by a HTGA coordinator. However, if a patient or a family member approaches you about donation, you should call Tissue Bank Manitoba at 940-1750 so that a coordinator can arrange to discuss donation options with them.

For a complete description of current reporting requirements, visit:

http://web2.gov.mb.ca/laws/statutes/ccsm/h180e.php OR

http://www.wrha.mb.ca/prog/tbm/index.php

The College of Physicians & Surgeons encourages physicians to make their patients aware of the value of organ and tissue donation and encourage them to share their decision with their families so that timely action can be taken when appropriate.

We're on the web

www.cpsm.mb.ca

PROVINCIAL PATIENT SAFETY CONFERENCE: LETS TALK ABOUT IT

WHEN: Wednesday 21 November 2007

WHERE: Winnipeg Convention Centre
375 York Avenue

May , 2007

To: Chairs of All Standards Committees

THE STANDARD

Inside this issue:

RECOMMENDATIONS FOR ORDERING DIAGNOSTIC IMAGING STUDIES

As part of their commitment to patient safety, the WRHA Diagnostic Imaging Program Standards Committee conducts case reviews to determine factors that contribute to occurrences. Recent reviews have demonstrated that there are opportunities for improvement in communication between referring physicians and DI staff. To this end, the following recommendations were developed in collaboration with Diagnostic Services Manitoba (DSM):

- All emergency and after hours diagnostic imaging requests should include an emergency contact number for the referring care provider and/or pager number to provide a route of urgent contact.
- Requisitions for diagnostic testing should have appropriate and legible clinical information regarding the patient's underlying condition.
- The referring care provider of the diagnostic test should be responsible for viewing or appointing a designate to review the emergency and/or after hours ward imaging study.
- As there always is a radiologist on call for the WRHA, in those circumstances where the ordering physician or their designate has difficulty interpreting the emergency diagnostic image, that physician can access the radiologist on call for assistance in the interpretation of the exam.
- Outside of Winnipeg, if a radiologist on call is available for specific, or all diagnostic imaging services provided by the healthcare facility, the ordering physician or their designate should access the radiologist on call for assistance in the interpretation of the exam if having difficulty interpreting the emergency diagnostic image. It is out of the radiographers' and sonographers' (x-ray and US technologist respectively) scope of practice to discuss preliminary findings with medical or nursing staff other that the reporting radiologists.
- That there should be a clear and legible name of the referring care provider ordering the exam and a name of the attending care provider for reporting purposes.
- It should be the ordering provider's responsibility to contact the patient when radiologist's report differs from the preliminary report by the ordering care provider.

Look for the 2003-2004 Maternal and Perinatal Health Standards Committee Report on CPSM website @ **www.cpsm.mb.ca**

PLEASE FEEL FREE TO DISTRIBUTE THIS NEWSLETTER WIDELY!!

Responsibilities at the Time of Death of a Patient

When a patient dies, physicians have two administrative responsibilities. Firstly, there is the question of whether to notify the medical examiner. Secondly, the death certificate will need to be completed.

When to notify the Office of the Chief Medical Examiner (OCME) is spelled out in the Province of Manitoba's Fatality Inquiries Act (Fig. 1). Practically, this means discussing the case with a medical examiner, or a medical examiner's investigator. The OCME will need to be involved in some natural deaths, and all non-natural (accident, homicide, suicide, undetermined) deaths. A checklist may be helpful, using the items listed in Figure 1 as a guide, for every death in the facility. In that way, errors will occur less frequently. Remember, for example, that someone dying of complications of a fall (e.g. hip fracture) or motor vehicle mishap, no matter how long after the initial event, is considered to have died an accidental death and must be reported. Someone whose residence is the Personal Care Home, but dies in a hospital must be reported. Any child death, expected or not, must be reported by law. When there is a question of notification, it is best to err on the side of notifying, and the examiner or investigator will determine whether they require further involvement. They may inform the physician to complete the death certificate, or take on that responsibility themselves. They may request further information, or arrange a post-mortem examination.

CLINICAL NOTES is a new feature for which Standards Committees are encouraged to submit contributions based on audit findings or raise questions that might be answered through new audit activities

A death certificate must be completed within 48 hours from the date of death, and prior to burial or cremation of the body. Accurate completion of the death certificate is important for a number of reasons. Families want to know the cause of death. Insurance companies may pay claims according to the cause of death. Governments and Health Systems use data provided on death certificates to determine what resources the population requires. The physician looking after the patient, or present at the time of death will be most able to complete the death certificate accurately. Inaccurate completion means someone somewhere may be guessing at the actual cause of death. Remember that the underlying cause of death is the disease that triggered the chain of events leading to the patient's death, without which death would not have occurred. It must occur on the lowest completed line of Part I and should be as etiologically specific as possible. An underlying cause of death can stand alone as the only completed line in Part I.

Figure 1. Deaths Reportable to the Medical Examiner [1]

A. The deceased appears to have died:

- i. As a result of an accident;
- ii. By an act of suicide, negligence, or homicide;
- iii. In an unexpected or unexplained manner;
- iv. As a result of poisoning;

As a result of contracting a contagious disease that is a threat to public health;

Suddenly of unknown cause;

During a pregnancy or while recovering from a pregnancy;

While under anaesthesia or while recovering from an anaesthesia or within 10 days of a surgical operation performed upon the person;

While in the custody of a peace officer;

As a result of: (a) contracting a disease or condition, (b) sustaining an injury, or (c) ingesting a toxic substance at the place of employment or former employment of the person;

Within 24 hours of admission of the person to a hospital;

In a place, institution or facility, or a class of place, institution or facility, that is prescribed under *The Fatality Inquiries Act* for purposes of Subsection 7(9) of *The Fatality Inquiries Act*; or

In circumstances that are prescribed under The Fatality Inquiries Act for purposes of Subsection 7(9) of The Fatality Inquiries Act;

B. At the time of death, the deceased person:

Was not under the care of a duly qualified medical practitioner for the condition that brought on the death; or

Was a resident of an institution or care facility that is licensed, or is required by an Act of the Legislature to be licensed, to operate as a residential institution or care facility;

C. The deceased person died while a resident in a correctional institution, jail, prison or military guardperson is room or in an institution to which The Mental Health Act applies; or

D. The deceased a child.

A number of documentation errors have been described in the completion of death certificates. These have been designated as major or minor errors.[2] Facilities could consider auditing their death certificates to determine which of these errors are occurring. Physicians are encouraged to complete death certificates in a prompt and accurate manner.

Physicians have important functions related to the death of their patient. They impact the patient's family, as well as the population as a whole, and should be performed with care and diligence.

References:

[1]Summarized from the Province of Manitoba's Fatal Inquiries Act

[2]Myers KA, Farquhar DRE. Improving the accuracy of death certification. CMAJ 1998;158(10):1317-23

Figure 2. Coding errors found on completed death certificates

Major Errors:

- Mechanism of death listed without an underlying cause
  - Mechanism or nonspecific condition listed as the underlying cause of death
- Improper sequencing
  - *Sequence of events does not make sense;*
  - *underlying cause of death not listed on the lowest completed line of Part I*
- Competing causes
  - *Two or more causally unrelated, etiologically specific diseases listed in Part I*

Minor Errors:

- Abbreviations
  - Abbreviations used to identify diseases
- Absence of time intervals
  - No time intervals listed in Part I or Part II
- Mechanism of death followed by a legitimate underlying cause of death
  - Use of a mechanism, but qualified by an etiologically specific cause of death

Submitted by Dr. Cornelius Woelk MD, CCFP, FCFP

SUBMISSIONS FOR PROVINCIAL PATIENT SAFETY CONFERENCE DUE OCTOBER 1, 2007

All employees, physicians and students in Manitoba's health care system are invited to submit a description of a "good catch" that **resulted in process improvements in patient safety and shared learning.**

FOR DETAILS CHECK OUR WEBSITE @ www.cpsm.mb.ca "Events"