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Review Date: September 2027
Review Lead: End of Life Care Facilitator

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Verification of Adult Expected Death for Registered Nurses and Physician Associates Policy

Version 5

Important: This document can only be considered valid when viewed on the Trust's Intranet. If this document has been printed or saved to another location, you must check that the version number on your copy matches that of the document online.

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Document Version Control	
Version No.	
1	Policy and training initiated, due to time delays in patients being verified, which had an adverse effect on relative distress and careof the patient after death.
2	Updated information including adding Physician associates beingincluded in the policy. Updated guidance from Hospice UK – February 2019
3	Updated information including updated guidance from Hospice UK (Jan 22) and the Coronavirus act 2020

4	Updated information from the Hospice UK (2023) guidelines and local ReSPECT implementation
5	Updated information from Hospice UK (2024) guidelines and new legislation around the medical examiner role

Contents

1. Introduction

Whilst the verification of death has been traditionally carried out by a medical practitioner, there is no requirement either legally or under the NHS Terms of Services, for a General Practitioner (GP) or Hospital Doctor to verify death. A fundamental review of death certification and investigation (Shipman Inquiry 2003) recommended that nurses should be able to verify that a death has occurred. This is supported by the Nursing and Midwifery Council (NMC 2012) which states:

"that whilst legally a nurse cannot certify death they may verify that death has occurred, providing that there is an explicit local policy".

The End of Life Care Strategy (DoH 2008) recommends nurse verification ofdeath to improve quality of care.

Verification of death is only to be undertaken by a First Level Registered Nurse (RN) with current NMC Registration who has undertaken appropriate verification of death training and has been assessed as being competent and assesses themselves as being competent in the knowledge and skills required for safe and effective practice (RCN 2016; Hospice UK 2015: 2019; 2022, 2023, 2024. NMC 2008). With the incorporation of Physician Associates (PA) into the multi-disciplinary team, equally with the provision of expected competency training, it has been agreed that the local policy can be extended to facilitate competent physician associates to also verify death.

2. Purpose

Registered nurses and physician associates working in primary and secondary care spend a significant amount of their time caring for patients with palliative care needs and supporting their carers. They are often with the patient at the time of death or are the first healthcare professional contacted by the family/carer when death is suspected. The End of Life Care strategy (DoH 2008) recommends nurse verification of death to improve the quality of care.

Current practice often involves the nurse or physician associate informally confirming death has occurred and contacting the doctor or out of hours service to verify death. Until this has been performed, no further action with regard to the patient can be taken. If this process is delayed because of the lack of availability of a doctor, significant distress can be caused to relatives and carers. The ability for registered nurses and physician associates to verify an expected death will enhance the care of the patient, their family and carers. It also makes the best use of resources, with care being delivered in a timely manner by the most appropriate person.

Aims and Outcomes
The expected outcomes of this policy are:

- That the death of the patient is dealt with in a timely, sensitive and caring manner, respecting the dignity of the patient, relatives and carers
- That verification of death in the hospital setting occurs within one hour of confirmed death and removal of the deceased patient from the ward occurs within four hours
- In the community setting verification of expected death occurs within 4hours (Hospice UK, 2024)
- The death of a patient is dealt with in accordance with legal requirements
- That relevant documentation is in place prior to verifying a death
- The verification of death is in accordance with guidance from regulatorybodies (NMC, 2008)
- Registered nurses and physician associates receive appropriate training to undertake verification of expected deaths and be deemed competent

3. Definitions

For the purpose of this policy the following definitions apply:

Adult is a person aged 18 years or above.

Death is the final cessation of vital functions in an organism, the state of beingdead (Oxford English Dictionary, 1996).

Recognition of death:
It is recognised that relatives, nurses, HCAs, nursing home staff and others can recognise that death has occurred.

Verification of the fact of death:
Verification of the fact of death documents the death formally in line with national guidance (Hospice UK, 2024) and is associated with responsibilities of identification, notification of infectious illnesses, and implantable devices (British Heart Foundation, 2013). This is recognised as the official time ofdeath.

Certification of death:
Certification of death is the process of completing the 'Medical Certificate of the cause of Death' (MCCD) which is completed by a medical practitioner in accordance with The Births and Deaths Registration Act 1953, underpinning the legal requirements for recording a person's death. From 9th September 2024 it becomes statutory law that any death that is not a referral to the Coroner has to be independently scrutinised and signed off by a Medical Examiner for that death to be registered – information can be found in Coroners & Justice Act 2009 and the Health & Care Act 2022.
The new legislation states that any Attending Practitioner who has attended the deceased any time in their life will be able to under their best belief and knowledge

provide a cause of death and complete a MCCD. Any doctor who has seen the deceased in life (this can be face to face or via video link) is able to complete the death certification process. If there is NO Doctor who has ever seen the patient in life the deceased will need to be referred to the Coroner.

Registering a death

Once the cause of death is confirmed by the attending Doctor and the medical examiner, and the declarations of certification and scrutiny have been completed, the MCCD is sent to the registrar. This is the point at which it will be possible for the representative of the deceased (who will be notified) to arrange the registration of the death through the registry office. It is a statutory requirement to register the death within five days. This timeframe will not start until the registrar receives notification of the cause of death from the medical examiner or a coroner. It may take longer for deaths to be certified and registered due to the need for a medical examiner to independently scrutinise and sign off the MCCD and for this to be sent to the registrar. Staff need to be aware that the time to register a death may have increased so they can provide reassurance/guidance to families about this.

Expected death:

An expected death is the result of an acute or gradual deterioration in a patient's health status, usually due to advanced progressive incurable disease. The death is anticipated, expected, and predicted.

It is anticipated in these circumstances that the following, where appropriate is in place; -

- Advance care planning,
- Completion of Electronic Palliative Care Coordinating Systems (EPaCCs) template,
- Anticipatory medicines prescribed,
- Palliative care plan completed,
- Documentation in the patient clinical records in the home, and on IT systems such as Systmone, EMIS and on EPR in the Hospital, that this patient is now palliative/end of life and death is expected +/- Individualised care of the Dying Document (ICODD) or Last Days of Life Document (LDLD),
- Completion of a DNACPR form or the DNACPR section of a ReSPECT form will have taken place.

Community patients

An expected adult death can be verified by a suitably qualified Community RN, if they are on the Calderdale Community Healthcare caseload.

Sudden or unexpected death:

Unexpected death is a death that is not anticipated or related to a period of illness that has been identified as terminal. Where the death is completely unexpected, and the healthcare professional is present then there is a requirement to begin resuscitation. There is further clear guidance from the Resuscitation Council UK for circumstances

where a patient is discovered dead and there are signs of irreversible death (Resus Council UK, 2021).

Sudden or unexpected death within a terminal period:
A patient with a terminal diagnosis can have a sudden death, e.g. an embolism. Death can be verified by an RN or PA. The RN/PA must be able to articulate and document clearly their actions and reasonings in these circumstances provided the DNACPR decision is documented, palliative / end of life care is documented in notes and the circumstances are discussed with the doctor.

The Coroner
The official person responsible for investigating deaths, particularly some of those happening under unusual circumstances, and determining the cause of death (see appendix 1 for deaths requiring coronial investigation)

4. Key Points

Inclusion criteria for VOED for registered nurses and physician associates.
This applies to registered nurses and physician associates, deemed competent, working within their care setting to verify the death of all adults(over the age of 18) providing all the following conditions apply:

- Death is expected and not accompanied by any suspicious circumstances.
- The 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) decision is documented.
- Death occurs in a private residence, hospice, residential home, nursinghome, prison or hospital.
- It includes where the patient dies under the Mental Health Act including Deprivation of Liberty (DOLS)
- The patient who dies at home is on the community caseload (including Specialist nursing caseloads) and is receiving end of life care
- It is documented in the patient clinical records in the home, and on IT systems such as Systmone, EMIS and on EPR in the Hospital, that thispatient is now palliative/end of life and death is expected +/- ICODD or LDLD, palliative care plans, EPaCCs, anticipatory medicines

In addition, consideration should be made to check the ultimate cause of death does not require to be reported to the coroner. **(When a death is reported to a Coroner,** https://www.gov.uk/after-a-death/when-a-death-is-reported-to-a-coroner**).**

Circumstances that would prevent the nurse from verifying - unexpected, unnatural or suspicious Death

- If any of the criteria (above, page 7) are not in place
- Is there any discrepancy with the medication?
- Is the syringe driver running to time?
- Do the stock control sheets comply with the numbers of drug ampoules in the

building?
- Cause of death is unknown
- Death was violent or unnatural
- Death was sudden and unexplained
- There are any other unusual or disturbing features to the case
- There is, or likely to be, an allegation of medical mismanagement.

The above is not an exhaustive list of the circumstances under which a death should be reported to the Coroner.

If there is a DoLS in place you are able to verify. However, you need tocheck: Did the care or lack of care play a part in the person's death?At the time of Verifying:
- Check with professional carer's and family for any concerns regarding care received or lack of care that may have contributed to the person's death.

If concerns are identified, please contact Coroner's officers to discuss specific cases further on 01274 438800 or via email: coronersofficeswest@westyorkshire.pnn.police.uk

5. Duties (Roles and Responsibilities)

Duties within the Organisation
This policy applies to registered nurses and physician associates employed by CHFT, whose role involves providing end of life care to patients that have completed the approved training and competency programme.

Role of the Medical Practitioner

A DNACPR decision is documented.

The doctor will be available if necessary to speak to families after death of the patient. This should be arranged at the soonest mutually convenient time.

The responsible doctor (or if necessary a delegated doctor) will always explain /be available to explain the cause of death they have written on the medical certificate.

Visit the deceased to verify death if no other competent healthcare professionalis available.

Verify death if the circumstances/conditions surrounding the death preclude a registered nurse or physician associate from undertaking the process.

Refer to the coroner if necessary or Complete the Medical Certificate of the cause of death (MCCD) at the first reasonable opportunity (after scrutiny by the ME).

Notification of infectious diseases, statements relevant to cremation and MCCDs are the responsibility of the medical practitioner.

Role of the Registered Nurse/ Physician Associate

All registered nurses/physician associates must have read and understood this guidance and have received appropriate training and deem themselves competent.

The registered nurses/physician associates carrying out this procedure must inform the doctor of the patient's death (both in and out of hours) using agreedlocal systems and document the date and time this was carried out in the clinical record.

The registered nurses/physician associates carrying out the procedure must notify the funeral director/mortuary of any infections, radioactive implants, implantable devices. Implantable cardio-defibrillators (ICD) should be deactivated prior to death, however, if it is active notify the funeral director/mortuary (see page 11) for information on how to instigate the processfor deactivation of ICD).

It is the right of the verifying nurse or physician associate to refuse to verify death and to request the attendance of the responsible doctor/police if there is any unusual situation. If the RN/PA has any concerns, for example, for patients with non - invasive ventilation, request the attendance of the responsible doctor to verify the death.

In the Community Setting -The patient is on a Calderdale community healthcare caseload and has been discussed with GP and community nursing team and it has been recognised that they are now end of life/palliative. For patients that are discharged from the hospital setting for EOLC, they should be referred to district nursing teams as soon as possible

In the Acute Setting – patient has been discussed with the medical team and Multi disciplinary team (MDT) and it has been recognised that the patient is now end of life.

All staff will acknowledge the limits of their professional competence and only undertake practice and accept responsibilities for those activities in which theyare competent.

Verification of expected death can be carried out in hospital, hospice, private residence, nursing or residential care home setting. The RN/PA must ascertain from both the professional carer's and (if possible) the family if any care given or lack of care played a part in the person's death before verification of death iscommenced. If there are any concerns the nurse must not verify the death.

If there are no concerns the RN/PA should ensure the relatives/carers understand and accept the verification of death will be undertaken by the nurse/physician associate before proceeding. Respect their wishes if they request the procedure to be carried out by a doctor.

In the event of the circumstances of a death precluding a RN/PA from undertaking verification, the patient's Hospital Doctor/on call Locum or Out of Hours Doctor has the responsibility to verify death and refer to the coroner if necessary.

Personal cares after death

Personal cares after death relates to the care given to a deceased patient after death and the nurse must ensure the process demonstrates respect for the deceased and is focused on respecting their religious and cultural beliefs.
Verification of death must be done before personal cares after death commence and any treatment is discontinued e.g syringe pump.

Hospital in-patient - all indwelling equipment to be left insitu, the mortuary team will remove.

Community patients - Medical treatments can be stopped prior to the VOED examination and can removed after the VOED examination.

Documentation
Excellent documentation standards are required throughout the process (NMC 2012).

6. Guidance for the Verification of Expected Death

Procedure for Verifying Expected Death
See flowchart for nurse verification of expected death (community staff) (see appendix 2).

Procedure Guide – Adapted from Hospice UK (2024)

Personal Protective Equipment (PPE)
To maintain the safety of the RN carrying out the verification of death, these guidelines should be used in conjunction with local policy and universal infection control precautions (Hospice UK, 2024)

Equipment (cleaned in accordance with local procedure):

- Pen torch
- Stethoscope
- Watch with second hand
- Disposable plastic apron
- Disposable gloves
- Disposable plastic waste bags
- Alcohol hand gel

Risk Assessment

The RN verifying the expected adult death should undertake a risk assessment with regards to the environment and potential infection status

➢ **ACTION**	**RATIONALE**
Adopt standard infection control precautions:	To ensure protection of the RN/PA from cross-contamination.
Check identification of the patient against available documentation, for example, clinical records, NHS or MRN number.	To correctly identify deceased.
Check for documented individualised agreement to DNACPR or equivalent in the clinical notes.	To ensure agreement of process.
Where a DNACPR is not available or in place, ensure clear clinical judgement that the death is irreversible.	To articulate and document decision not to commence CPR.
Identify any suspected or confirmed infectious diseases, radioactive implants, implantable medical devices. **See the 'Notification of Infectious Diseases' section in Appendix 1.*	To enable correct information to be passed on to ensure others involved in the care of the deceased are protected.

ACTION	**RATIONALE**
Where applicable, instigate the process for deactivation of Implantable Cardiac Defibrillator (ICD), if not already deactivated. For deactivation: **Office hours** - Contact the devices team on CRH ext 4020 or Cardiology on CRH ext 4310. **Out of hours** - ring CRH switchboard on 01422 357171 and ask for cardiologist on call.	To ensure the timely deactivation of ICD.
Lie the patient flat Leave all tubes, lines, drains, medication patches and pumps, etc. in situ (switching off flows of medicine and fluid administration if in situ), and spigot off as applicable and explain to those present why these are left at this time	To ensure the patient is flat ahead of rigor mortis. To ensure all treatments are stopped prior to the verification of death examination. **Hospital patients** - All indwelling equipment to be left insitu, the mortuary team will remove. **Community patients -**These may be removed after the verification of death examination
VERIFICATION OF DEATH EXAMINATION **The individual should be observed by the person responsible for verifying death for a minimum of five (5) minutes to establish that irreversible cardio-respiratory arrest has occurred.** ***NOTE a change in the order of examination to minimise contamination of equipment*** NB: In the rare case of a patient having non-invasive ventilation (NIV), and the patient has died, the NIV will cause the chest to continue to rise and fall, mimicking respiratory effort from the patient. However,	

you would anticipate that all other signs of life are absent. It is recommended that the ventilator be switched off and continued checking for a pulse, alongside auscultating for the presence of a heartbeat, occurs. Following this, the verification process should be followed, ensuring all checks are conducted over the 5-minute period. If there are any doubts or concerns over verifying the death, it is advisable to liaise with the GP or other medical practitioner.	
Heart Sounds For at least 2 minutes, using the stethoscope, listen for heart sounds through the clothing/nightclothes.	To ensure there are no signs of cardiac output.
Neurological Response Using the pen torch, test both eyes for the absence of pupillary response to light.	To ensure there is no sign of cerebral activity.
Respiratory Effort Observe for any signs of respiratory effort over the five minutes.	To ensure there are no signs of respiratory effort.
ACTION	**RATIONALE**
Central Pulse Palpate for a central pulse and if necessary, through the clothing/night clothes for at least 1 minute	To ensure there are no signs of cardiac output.
Motor Response After five minutes of continued cardio-respiratory arrest, test for the absence of motor response with the trapezius squeeze or the absence of cerebral activity with supra orbital pressure, which is considered best practice.	To ensure there are no signs of motor or cerebral activity.
Any spontaneous return of cardiac or respiratory activity during this period of observation should prompt a further five minutes of observations.	

In hospital, ensure the patient is identified correctly with two name bands in situ completed with: name, date of birth, address, or NHS number /MRN number.	To ensure the patient is identifiable.
Dispose of waste in line with local policy for waste management of clinical waste.	To ensure correct management of infective clinical waste in patient's own homes.
Perform hand hygiene following removal and disposal of PPE.	Follow local infection prevention and control standards in correct management of contaminated PPE.
The RN/PA verifying the death needs to complete the local verification of death form. Community – Complete the confirmation of fact of death form (see appendix 3a) Hospital – Document on EPR records Time of death is recorded as when verification of death is completed (i.e. not when the death is first reported).	For legible documentation and legal requirements.
ACTION	**RATIONALE**
The RN/PA must notify the doctor of the death (including date / time) by secure email or their locally agreed procedure.	To ensure consistent communication.
The RN/PA verifying the death must acknowledge the emotional impact of the death and ensure the bereaved family and friends are offered information about "the next steps".	To ensure the family are supported during this difficult time.
The RN/PA verifying death should understand the potential / actual emotional impact of bereavement on surrounding patients and residents in a communal setting and prompt colleagues and paid carers to provide appropriate support.	To ensure surrounding patients and residents are supported during this difficult time.
The RN/PA verifying death should understand the potential / actual emotional impact of bereavement for colleagues and paid carers and guide them towards appropriate support.	To ensure colleagues and paid carers are supported during this difficult time.

Community
When verifying death, the verifying RN/PA must record in the patient's clinical record and complete the nurse verification of expected death checklist (see appendix 3b). The nurse verification of expected death checklist should be scanned onto the Systmone records. A 'Confirmation of Fact of death' form also needs completing and should be left with the deceased (see appendix 3a). The nurse conducting VOED should record the stock balance of all anticipatory medications on the pink stock balance charts in the nursing notes. The nursing notes should be returned to DN office for safe keeping asap.

Hospital
When verifying a death in Hospital it must be documented on the EPR records.Please document information below;

- The date of death
- The time of death (ascertained by when complete verification of death)
- Identity of any person present at the death or, if the deceased was alone, or the person who found the body
- Circumstances of death (e.g. place of death)
- Clinical signs of death (absence of papillary reaction, heart and respiratory sounds)
- Name of doctor informed and the time and date this took place

Sign the death notification which accompanies the deceased patient to the mortuary.

Advice for relatives
The RN/PA should advise the deceased's relative that, the patient's own doctor will be able to issue a medical certificate of the cause of death once approval by the Medical Examiner's office has been granted. In exceptional circumstances eg.,where there is a cultural or religious imperative for prompt burial or cremation in the UK and there is no requirement to refer to the coroner, efforts should be made to accommodate this request where possible.
The ME service appreciates that the needs of all bereaved relatives are important and appreciate that the needs of certain communities after the death of a loved one are specific. They aim to respond to those needs in an inclusive, respectful way as far as possible. However, they also have a statutory responsibility undertake their job to the best of their ability, and if that requires them to take more time to consider the details of complex cases, then they will. They will keep the bereaved relatives up to date with the progress of our scrutiny.

Parenteral drug administration equipment or any life prolonging equipment should not be removed prior to verification of death. If the clinician has any concerns that the death may have been in suspicious circumstances, the policemust be informed.

Legal Position
Funeral Directors require a health professional to verify that death has occurred before removing the deceased person. In hospital the deceased person must be collected from the Mortuary.

Following verification of expected death by a registered nurse or physician associate it is still necessary for a doctor to complete a medical certificate of the cause of death after referral, scrutiny, and agreement by the Medical Examiner. From 9th September 2024 it becomes statutory law that any death that is not a referral to the Coroner has to be independently scrutinised and signed off by a Medical Examiner for that death to be registered – information can be found in Coroners & Justice Act 2009 and the Health & Care Act 2022.

There is no statutory (legal) duty for a doctor to report deaths to the coroner.However, the doctors have voluntarily assumed the primary responsibility forsuch reporting.

7. Trust Equalities Statement

Calderdale and Huddersfield NHS Foundation Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. We therefore aim to ensure that in both employmentand services no individual is discriminated against by reason of their gender, gender reassignment, race, disability, age, sexual orientation, religion or religious/philosophical belief, marital status or civil partnership.

This policy has been through the Trust's EQUIP (Equality Impact Assessment Process) to assess the effects that it is likely to have on people from different protected groups, as defined in the Equality Act 2010.

8. Training and Implementation

Training and eligibility to undertake VOED In the Community setting.

The qualified nurse must have a minimum of one years' post registration experience, plus their line manager's approval.

In Hospital
Verification of death can only be performed if RNs have a minimum of oneyears' post registration experience and are also part of the ART (Acute Response Team) night matrons, clinical site commanders and ANP group of staff.

Physician Associates must have 6 months' post qualifying experience.

Training

Colleagues are requested to read the Verification of Expected Death Policy andGuidelines prior to attending the face to face/virtual training.

The face to face/virtual training consists of theory and following this a nursing simulation laboratory element is accessible if required. If following the training the RN/PA doesn't deem themselves competent they can watch and be watched performing VOED by competent colleagues. (See Appendix 4 for the competency form).

CHFT colleagues are accountable for achieving, maintaining and collating evidence of competence with respect to verifying an expected death in accordance with their own professional registration bodies. This can be by reflection on practice and kept within personal/ individual portfolios.
CHFT colleagues are accountable for only carrying out aspects of care for which they deem themselves competent at the time and in the circumstances the care is required.

Registered nurses/ Physician Associates are able to access a refresher session if they have not verified a death within the previous year or identifies a necessity to ensure their competence within supervision or the Personal Development Review (PDR) process.

Competence

First level registered nurses must have attended the face to face/virtual training and deem themselves competent in the 'Theoretical and clinical competency assessment for verification of expected death' document (see appendix 4) in order to attempt to verify an expected death.

Nurses may require further support within their clinical teams to gain competence. At all times nurses must comply with the NMC requirements on competency which state that nurses must 'recognise and work within the limits of your competence' (NMC, 2015).

For PAs – They must have attended the face to face/virtual training and deem themselves competent in the 'Theoretical and clinical competency assessment for verification of expected death' document (see appendix 4) in order to attempt to verify an expected death.
Plus carried out a mini-cex.

Face to face/Virtual training and refresher sessions can be accessed by contacting the clinical educator in end of life care at Overgate Hospice.

The training will cover:

- Legal and ethical issues
- Procedure for the Verification of Death
- Preservation of evidence
- Ascertaining suspicious circumstances
- The role of the Coroner
- Documentation
- Communication
- Role of the verifier and role of the medical practitioner

Training will result in the following:

- To be able to differentiate between an expected and unexpected death
- To recognise when it is not appropriate for a Registered Nurse or Physician Associate to verify a death
- To be able to undertake the procedure to verify that the patient has died
- To appreciate and recognise the role of the coroner
- The preservation of evidence in cases of suspicious death

- To understand the legal issues, accountability and documentation

9. Financial Impact

There is no financial impact as a result of this policy.

10. Monitoring Compliance

Records of verification of death by qualified nurses will be kept and maintained in accordance with Records Management Policy and procedures. Records of training undertaken must be maintained and the staff who have undertaken VOED training will be added to ESR.

The clinician should maintain evidence of all training and competency assessment undertaken in their professional portfolio. Records may be audited to monitor compliance with guidelines.

Monitoring of this guidance will be the responsibility of clinical leads.

11. Associated Documents/Further Reading

An overview of the death certification reforms - GOV.UK (www.gov.uk) Updated 14 August 2024

Coroners and justice act 2009 - Coroners and Justice Act 2009 (legislation.gov.uk)

Health and care act 2022 - Health and Care Act 2022 (legislation.gov.uk)

National Council for Palliative Care (2015) Every moment counts: a narrative for person centred coordinated care for people near the end of life. Available at: http://www.nationalvoices.org.uk/sites/default/files/public/publications/every_moment_counts.pdf

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Resuscitation Council UK (2007) Decisions relating to cardiopulmonaryresuscitation; a joint statement from the British Medical Association, theResuscitation Council (UK) and the Royal College of Nursing. RC (UK)http://www.resus.org.uk/pages/dnar.pdf

Royal College of Physicians (2009) Advance Care Planning London: RoyalCollege of Physicians http://www.rcplondon.ac.uk/pubs/contents/9c95f6ea-c57e-4db8-bd98-fc12ba31c8fe.pdf

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Hospice UK (2023) 5th edition of care after death. Registered nurse verification of expected death (RNVoED) guidance

Hospice UK (2024) 6th Edition of care after death. Registered Nurse Verification of Expected Adult Death (RNVOEAD) guidance RNV0EAD 6th Edition Final Version April 2024.pdf

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APPENDIX 1 – Deaths requiring coronial investigation

Deaths requiring referral to coroner's office for investigation (Ministry of Justice, 2020)

- the cause of death is unknown
- there is no attending practitioner(s) or the attending practitioner(s) are unavailable within a prescribed period
- the death may have been caused by violence, trauma, or physical injury, whether intentional or otherwise
- the death may have been caused by poisoning
- the death may be the result of intentional self-harm
- the death may be the result of neglect or failure of care
- the death may be related to a medical procedure or treatment
- the death may be due to an injury or disease received in the course of employment or industrial poisoning
- the death occurred while the deceased was in custody or state detention, whatever the death.

A person who dies from a notifiable infectious disease, e.g. COVID-19, is not a reason on its own to refer the death to the coroner (Lawrie, I. & Murphy, F., 2020)

Notification of infectious diseases

Notifiable diseases are nationally reported in order to detect possible outbreaks of disease and epidemics as rapidly as possible, and it is important to note: Gov.UK. (2021:3)

- Diagnosis of suspected (and/or confirmed) COVID-19 is a notifiable infectious disease.
- Registered medical practitioners have a statutory duty to inform their local health protection team of a diagnosis of a suspected notifiable infections disease, and without waiting for laboratory confirmation, at time of diagnosis.
- All laboratories where diagnostic testing is carried out must notify Public Health England of any confirmation of a notifiable infectious disease.
- Registered medical practitioners are required to report COVID-19 positive deaths to NHS

  England.

Guidance for registered medical practitioners on the Notification of Deaths Regulations (publishing.service.gov.uk) March 2022

Appendix 2 - Flowchart for nurse verification of expected death (Community staff)

Flowchart for nurse verification of expecte

Appendix 3a – For Community use only – Confirmation of fact of death form to be left with the deceased

11. CONFIRMATION OF FACT OF DEATH

Appendix 3b - Verification of Death Checklist

Verification of death checklist.docx

Appendix 3b - Guide for Calderdale Community Staff to document Nurse verification on Systmone

Guide for Calderdale staff add

Appendix 4 - Assessment of Theoretical and Clinical Competence for Registered Nurse Verification of Expected Adult Death (Adapted from hospice UK 2024)

Competency document VOED am