UNIQUE IDENTIFIER NO: C-93-2015
EQUIP-2019-046
Review Date: March 2025
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 3

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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Locala End of Life Care Facilitator		June 2019
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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 care of the patient after death.
2	Updated information including adding Physician associates being included 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

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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 of death 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, 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 4 hours (Hospice UK, 2022)
- 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 regulatory bodies (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 being dead (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, 2022) 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. In hospital the Medical examiners provide independent scrutiny to all deaths which do not fall under the jurisdiction of HM Coroner. This is now a statutory requirement under the 2009 Coroners & Justice Act.

Only a doctor who has attended the deceased for their last illness will be allowed to complete a MCCD.

Any doctor who has seen (this can be face to face or via video link) the deceased within 28 days prior to death can complete an MCCD if they are satisfied they can offer a cause of death.

Any doctor who has attended the deceased **during their final illness** (even if it is more than 28 days before death) can complete an MCCD **if they** are satisfied they can offer a cause of death **and have also seen the deceased directly after death** (this must include verifying the death.)
Where the doctor (i) did not attend the deceased in the 28 days before death, and (ii) did not attend the deceased in person to verify death, then the MCCD can still be completed by a doctor who has attended the deceased for their last illness, if they can state the cause of death to the best of their knowledge and belief. However, the coroner must be notified of this. Ideally the coroner will be notified by the certifying medical practitioner prior to registration of the death, to minimise distress to the bereaved. However, it is permissible for the coroner to be notified at the time of registration of the death. The coroner may then complete Form 100A and send this to the registrar to allow registration.

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 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 will have taken place.

Community patients

The death can be verified even if the doctor has not seen the patient in the previous 28 days, as long as 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.
The national resuscitation council has issued clear guidance for the circumstances where a patient is discovered dead and there are signs of irreversible death (Resus Council UK, 2017).

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 form is completed, palliative / end of life care is documented in notes and the circumstances are discussed with the doctor.

The Coroner
The official 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) documentis completed.
- Death occurs in a private residence, hospice, residential home, nursing home, 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 this patient 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 aCoroner,** https://www.gov.uk/after-a-death/when-a-death-is-reported-to-a- coroner**)**

Circumstances that would prevent the nurse form 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 to check:
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 carereceived or lack of care that may have contributed to the person's death.

If concerns are identified, please contact Coroner's officers to discuss specificcases further on 01274 373721 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 byCHFT, 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 (See Appendix 2).

The doctor will be available if necessary to speak to families after death of thepatient. 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.

Any doctor who has seen (this can be face to face or via video link) the deceased within 28 days of death can complete an MCCD if they are satisfied they can offer a cause of death.
Any doctor who has attended the deceased **during their final illness** (inferring this is over 28 days before death) can complete an MCCD **if they have also seen the deceased directly after death** and are satisfied they can offer a cause of death

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

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

Issue the death certificate at the first reasonable opportunity (after scrutiny by the MEO in the acute Trust) in readiness for collection by relatives/Funeral Director with the exception in certain cases, e.g.death from industrial disease where a post mortem and inquest may be required.

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 agreed local 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 14) for information on how to instigate the process for 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 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 they are 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 is commenced. 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 community staff (see Appendix 3).

Procedure Guide – Adapted from Hospice UK (2022)

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 applied to all verifications of expected adult death irrespective of any COVID-19 status (i.e. not suspected, suspected, confirmed), by donning surgical mask, eye protection, gloves and apron as a minimum when carrying out the verification of death procedure (Hospice UK, 2020)

Equipment (cleaned in accordance with local procedure):

- *Pen torch
- *Stethoscope
- *Watch with second hand
- **Surgical face mask
- Eye protection
- Disposable plastic apron
- 2 pairs of clean disposable gloves
- Single use, small clean disposable sheet
- Disposable plastic waste bags
- Alcohol hand gel

**For visits to patient's own home, this equipment should be suitably cleaned prior to entering the home and prior to leaving.*

*** Where Covid-19 is suspected of confirmed, an additional face mask is required to place over the deceased's mouth when moving them.*

The RN may need a 'clean buddy' in order to help with infection control procedures

Risk Assessment

The RN verifying the expected adult death should undertake a risk assessment with regards to all PPE selection

- Eye protection/Face visor: where there is a risk of contamination to the eyes from splashing secretions including body fluids, a surgical mask with visor or surgical mask and goggles should be worn, along with a single-use gown (Gov.UK, 2021:1). Where there is risk of contamination from respiratory droplets, when moving the patient, a barrier such as a cloth or face mask is required to place over the deceased's mouth when moving them (Public Health England, 2020).

- Disposable apron/gown: plastic aprons must be worn for all iterations to protect staff uniform from contamination. Fluid-resistant gowns should be worn where there is a high risk of extensive splashing of secretions or body fluids, and where a plastic apron is not sufficient.

- Equipment: ensure stethoscope and pen torch are thoroughly cleaned with disinfectant wipes Clinical Notes: these should be accessible to the RN in clinical settings, or care homes ahead of the process of verifying death. This may not be the case in the patient's own home.

- Home Visits:

➢ If verification is to take place in a patient's home, take soap, disposable towels, and alcohol hand gel to ensure suitable hand hygiene.

➢ It is helpful if a distance of at least 2 metres (6 feet) can be maintained between you and any family members present, particularly if they are unwell.

Where infection is suspected or confirmed, ensure small plastic waste bags are taken into the patient's home. Any waste should be disposed of in the bag and tied when three-quarters full placed in the general waste. Gov.uk (2021:2)

➢ **ACTION**	**RATIONALE**
Adopt standard infection control precautions: Perform hand hygiene prior to donning selected PPE	To ensure protection of the RN 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. Where a DNACPR is not available or in place, ensure clear clinical judgement that the death is irreversible.	To ensure agreement of process. To articulate and document decision not to commence CPR.
Identify any suspected or confirmed infectious diseases*, radioactive implants, implantable medical devices. NB: COVID-19 may not have been documented in the notes. **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.
Where applicable, ask a relative to ensure that a window is opened in the patient's home for ventilation	To allow circulation of fresh air and reduce viral load.

ACTION	RATIONALE
Where applicable, instigate the process for deactivation of Implantable Cardiac Defibrillator (ICD), if not already deactivated. For deactivation; Contact cardiology on CRH ext 2310 or HRI ext. 2388. Out of hours - contact cardiac physiologist through on call cardiologist)	To ensure the timely deactivation of ICD.
Open clean disposable sheet onto a cleaned surface, place suitably cleaned stethoscope and pen torch onto the clean disposable sheet. (For home visits, this may be a dressing pack containing the required gloves, apron, waste bag and sheet).	In readiness for the verification.
Lie the patient flat.	To ensure the patient is flat ahead of rigor mortis.
Where COVID-19 is suspected or confirmed, place a barrier, such as a cloth or face mask, over the mouth of the patient when moving them.	To prevent the potential release of respiratory tract droplets on movement.
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 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***	
Heart Sounds Using the stethoscope, listen for heart sounds through the clothing/nightclothes. Place stethoscope on clean sheet.	 To ensure there are no signs of cardiac output. Ready for cleaning.
Neurological Response Using the pen torch, test both eyes for the absence of pupillary response to light. Place pen torch on clean sheet.	 To ensure there is no sign of cerebral activity. Ready for cleaning.

Respiratory Effort Observe for any signs of respiratory effort over the five minutes. NB Do not place your ear near to the person's nose or mouth to listen for breathing.	 To ensure there are no signs of respiratory effort. To avoid any risk of contamination.
ACTION	**RATIONALE**
Central Pulse Palpate for a central pulse and if necessary, through the clothing/night clothes.	 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. Carry out the trapezius squeeze through the clothing/night clothes.	 To ensure there are no signs of no cerebral activity. To minimise movement of the person and reduce contamination.
Any spontaneous return of cardiac or respiratory activity during this period of observation should prompt a further five minutes of observations.	
Take off first pair of gloves and dispose of in the small waste bag whilst leaving on the remaining PPE. Perform hand hygiene and don clean pair of disposable gloves. Clean the stethoscope and pen torch with disinfectant wipes and place in a clean bag.	To discard contaminated gloves safely prior to cleaning the equipment To ensure hands are clean prior to donning clean gloves to decontaminate equipment. Follow local infection control procedure for decontamination of equipment.

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.
Remove gloves and dispose of into the waste bag.	To safely dispose of contaminated gloves.
Remove PPE in the correct order including hand hygiene and place in waste bag.	To eliminate cross-contamination from the equipment to anyone else.
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 verifying the death needs to complete the local verification of death form. Community – Complete the confirmation of fact of death form (Appendix 4b) 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 must notify the doctor of the death (including date / time) by secure email or their locally agreed procedure.	To ensure consistent communication.
The RN 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 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 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.

Verifying of expected death documentation

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 4a). The nurse verification of expected death checklist should be scanned onto the Systmone records. A 'Confirmation of Fact of death' form alsoneeds completing and should be left with the deceased (see Appendix 4b). 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, orthe person who found the body
- Circumstances of death (e.g. place of death)
- Clinical signs of death (absence of papillary reaction, heart and respiratorysounds)
- Name of doctor informed and the time and date this took place

Complete and sign the Death notification which accompanies the deceased patient to the mortuary (see Appendix 5).

Advice for relatives

The RN/PA should advise the deceased's relative that, except under certain circumstances, the patient's own doctor will be able to issue a medical certificate of the cause of death within 24 hours of the patient's death, unless atweekends and bank holidays when the certificate should be made available on the next working day. In exceptional circumstances (compliance with religious and cultural beliefs surrounding burial) it may be possible to arrange death certification in the OOH period. This would only be available with prior consultation with the Doctor.

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 police must 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.

There is no statutory (legal) duty for a doctor to report deaths to the coroner. However, the doctors have voluntarily assumed the primary responsibility for such 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 employment and 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 one years' post registration experience and are also part of the HOOP, 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 and Guidelines 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 doesn't deem themselves competent they can watch and be watched performing VOED by competent colleagues. (See Appendix 6 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 the nurse/PA has 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 6) 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 6) 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 qualified nurse or PhysicianAssociate 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

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_mo ment_counts.pdf

Coroners, post-mortems and inquests: Directgov – Government, citizens and rights http://www.direct.gov.uk/en/Governmentcitizensandrights/Death/WhatToDoAfte rADeath/DG_066713

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Resuscitation Council UK (2007) Decisions relating to cardiopulmonary resuscitation; 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

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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.

More detailed information is available from the Ministry of Justice publication below; Ministry of Justice (2014). Guide to coroner services. Available at:https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/36387 9/guide-to-coroner-service

APPENDIX 2 - Do Not attempt Cardiopulmonary Resuscitation (DNACPR) Form

DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION

Yorkshire & Humber Regional Form for Adults and Young People aged 16 and over (v13)

In the event of cardiac or respiratory arrest NO attempts at cardiopulmonary resuscitation (CPR) will be made. All other treatment should be given where appropriate.

NHS No	Hospital No	Next of Kin / Emergency Contact
Name		
Address		Relationship
Postcode	Date of Birth	Tel Number

Section 1 Reason for DNACPR decision: Select as appropriate from A - D

Details of all discussions, mental capacity assessments and MDT decisions must be recorded in the patient's notes.

(Guidance overleaf)

A. ☐ **CPR has been discussed with this patient. It is against their wishes and they have the mental capacity to make this decision.**

(Guidance overleaf)

B. ☐ **CPR is against the wishes of the patient as recorded in a valid advance decision**
The right to refuse CPR in an Advance Decision only applies from the age of 18.

(Guidance overleaf)

C. ☐ **The outcome of CPR would *not* be of *overall benefit* to the patient and:**
i) They lack the capacity to make the decision ☐ **or**
ii) They have declined to discuss the decision ☐
This represents a best interests decision and must be discussed with relevant others

This **has** been discussed with ……(name) on…… (date/time) Relationship to patient:……

(Guidance overleaf)

D. ☐ **CPR would be of *no clinical benefit* because of the following medical conditions:**

……

In these situations when CPR is not expected to be successful, it is good practice to explain to the patient and/or relevant others why CPR will not be attempted.

This **has** been discussed with the patient ☐ Date:……/……/…… Time: ……

This **has not** been discussed with the patient ☐ *Specify Reason:* ……

This **has** been discussed with ……*(name)* on ……(date/time) Relationship to patient:……

Section 2 Review of DNACPR decision: Select as appropriate from i OR ii

i) DNACPR decision is to be reviewed by: …… *(specify date)*

Review Date	Full Name and Designation	Signature	DNACPR still applies	Next Review Date
			☐ *(tick)* ☐ *(tick)*	
			☐ *(tick)*	

ii) DNACPR decision is to remain valid until end of life ☐ *(tick)*

Section 3 Healthcare professionals completing DNACPR form *(Guidance overleaf)*

Date: …… Time: ……
Signature: ……
Print name: ……
Designation & Organisation ……
GMC / NMC No: ……

(Countersignature if required)
Date: …… Time: ……
Signature: ……
Print name: ……
Designation & Organisation ……
GMC / NMC No: ……

These guidelines are based on an agreement within the Yorkshire and Humber region.
This form can be red or black-bordered.
For more details refer to your local policy relating to DNACPR.
This is not a legally binding document; the decision may change according to clinical circumstances

Section 1 Guidance (*Please write legibly and with black ink*)

Option A

Record details in the patient's notes, including the assessment of the patient's mental capacity to make this decision.

Option B

The Mental Capacity Act (2005) confirms that an advance decision refusing CPR will be valid and therefore legally binding on the healthcare team, if:

1. The decision is in writing, signed, witnessed and the patient is aged 18 or over;
2. It includes a statement that the advance decision is to apply even if the patient's life is at risk;
3. The advance decision has not been withdrawn;
4. The patient has not, since the advance decision was made, appointed a welfare attorney to make decisions about CPR on their behalf;
5. The patient has not done anything clearly inconsistent with its terms; and
6. The circumstances that have arisen match those envisaged in the advance decision.

16 and 17-year-olds: *Whilst 16 and 17-year-olds with capacity are treated as adults for the purposes of consent, parental responsibility will continue until they reach age 18. Legal advice should be sought in the event of disagreements on this issue between a young person of 16 or 17 and those holding parental responsibility*

Option C

1. The term "*overall benefit*" is used in the context defined by GMC Guidance 2010 (Treatment & Care towards the End of Life; pg. 40-46; paragraphs 6, 13) and takes into account "*best interests*" as defined by the Mental Capacity Act, 2005.
2. Whenever possible, this situation **must** be discussed with relevant others before completing the form. Record details of your discussion in the patient's notes.
3. The term "*relevant others*" is used to describe a patient's relatives, carers, representatives, people with lasting power of attorney, independent mental capacity advocates (IMCAs), advocates, and court appointed deputies (refer to Mental Capacity Act) http://www.dh.gov.uk

Option D

Record underlying condition/s (e.g. poor Left Ventricular Function, End stage obstructive airway disease, disseminated malignancy) and complete necessary discussions with patient and/or relevant others as soon as possible

Section 2 Review – In accordance with your Local Policy

It is considered good practice to review DNACPR status in the following circumstances:

- At the consultant ward round, MDT or Gold Standards Framework meeting;
- On transfer of medical responsibility (e.g. hospital to community or vice versa); or
- Whenever there are significant changes in a patient's condition.

Cancellation of DNACPR: When the form is no longer valid, either because the patient is for CPR or because a new form has been completed, it must be marked as cancelled by making two thick, dark, diagonal lines across the form, writing **CANCELLED** in large capitals and adding your signature and date. It should then be filed in the patient's notes.

Section 3 Authorisation

Responsibility for making the DNACPR decision lies with a senior doctor (e.g. Consultant, GP) who has responsibility for the patient. In some localities, other healthcare professionals who have undertaken the necessary training may make the DNACPR decision.

Countersignature: If junior medical staff or other authorised professionals have been instructed to sign the form by a senior clinician, the form should be countersigned by the senior doctor, as soon as possible or as per local policy.

Any supplementary information (e.g. family informed by nursing staff at later stage) should be signed and dated by the entry.

COMMUNICATING DNACPR DECISIONS

It is the responsibility of the healthcare team completing the form to ensure that the DNACPR status is communicated to all who need to know.

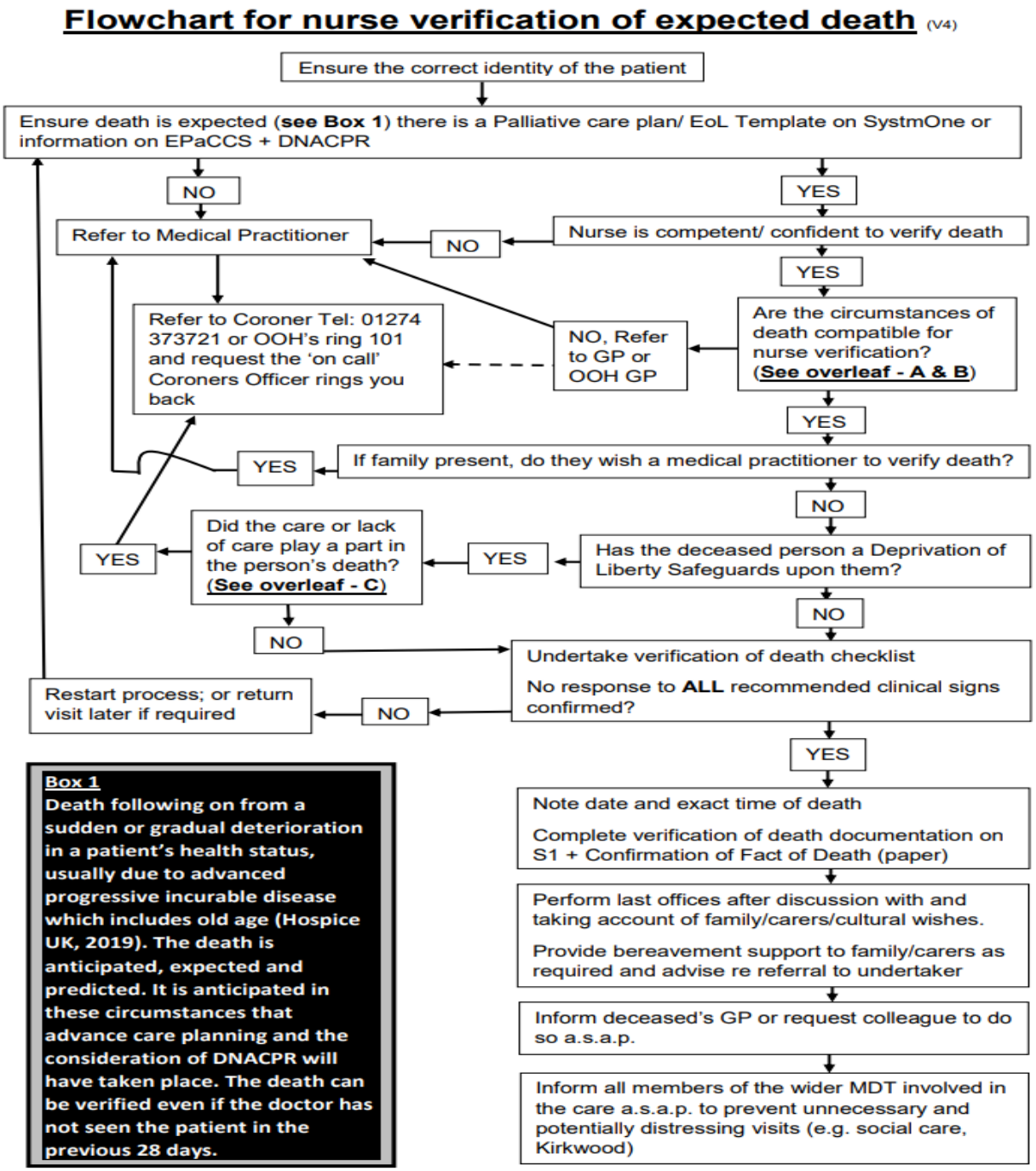
For patients being transferred between different care settings, it is essential that:

1. Where patients are being transferred to community (e.g. home or care home): the DNACPR status and an explanation of the role of the form in an emergency should be communicated to patient (if appropriate) and '*relevant others*'.
2. Send the **original form** with the patient. A photocopy or carbon copy version should be retained in the patient's notes for audit, marked with the words '**COPY**' in large capitals, signed and dated.
3. For discharges to community settings: communicate to the GP, Out of Hours service and any other relevant services as appropriate.

v13 January 2014
Regional Review Date: January 2023
Regional Lead Contact: Palliative Medicine Consultant
Calderdale & Huddersfield NHS Foundation Trust. West Yorkshire

APPENDIX 3

Flowchart for community staff



Flowchart for nurse verification of expected death (V4)

A. Are the circumstances of death compatible with verification by a registered nurse?

Criteria that need to be in place for a nurse to verify an expected death:

- *Palliative care plan is attached to the person's individual care record*
- *Person has a DNACPR form or evidence within the clinical record of one or* there are signs of irreversible death
-

B. Are there any circumstances that would prevent the nurse form verifying and would indicate a referral to a GP?

- *If any of the criteria (above) 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?*
- *death was sudden, unexplained, violent or unnatural*
- *there are unusual or disturbing features to the situation*
- *there is, or likely to be, an allegation of medical mismanagement*
- *medical certificate suggests the death may have been caused by an industrial disease or industrial poisoning (for example old or new Creutzfeldt-Jakob disease, pneumoconiosis, mesothelioma)*
- *there are any other unusual or disturbing features to the case*
- *there is, or likely to be, an allegation of medical mismanagement*

For further information regarding Deaths reported to the Coroner see Births, Deaths, Marriages and care (2020). When a death is reported to a coroner. https://www.gov.uk/after-a-death/when-a-death-is-reported-to-a-coroner?step-by-step-nav=4f1fe77d-f43b-4581-baf9-e2600e2a2b7a

Or contact the Coroner's officers to discuss specific cases further on 01274 373721 or via email: coronersofficeswest@westyorkshire.pnn.police.uk or contact 101 and ask to speak to the coroners officer's.

C. If there is a DoLS in place – YES
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/or family for 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 373721 or via email: coronersofficeswest@westyorkshire.pnn.police.uk

UNIQUE IDENTIFIER NO: C-93-2015
EQUIP-2019-046
Review Date: March 2025
Review Lead: End of Life Care Facilitator

Appendix 4a

For community use only - Verification of Death Checklist

Patient Full Name:	
NHS No:	Date of Birth:
Address:	
Date of Death:	Time of Death:
Patient's Identity Confirmed By:	
Patient's Home Address:	
Place of Death (if different from above):	
Persons Present at Time of Death: or if alone, who found the body (if none, state none)	

Death is confirmed when all the following criteria are met, a person is observed for a minimum of five minutes and if during that time there is any return of circulation or breath sounds a further five minutes of observation should be carried out. Confirm all criteria with a YES in the box.

A person needs to be observed by the person responsible for verifying death for a minimum of 5 minutes to establish that irreversible cardio-respiratory arrest has occurred		
1	Heart Sounds: Using a stethoscope, listen for **TWO** minutes for heart sounds through the clothing/ nightclothes	Select
2	Neurological Response: Using a pen torch, test both eyes for the absence of pupillary response to light	Select
3	Respiratory Effort: Observe for any signs of respiratory effort over five minutes – **DO NOT PLACE YOUR EAR NEAR TO THE PERSON'S NOSE/MOUTH**	Select
4	Central Pulse: Palpate for one minute either carotid or femoral central pulse through the clothing	Select
5	Motor Response: Test for absence of motor response through clothing with the trapezius squeeze (use thumb and 2 fingers to grasp the trapezius muscle, exert pressure/ twist)	Select
Any spontaneous return of cardiac or respiratory activity during this period of observation should prompt a further five-minute observation		

Time of Verification of Death (24-hour clock):					
Date:					
Signature of Verifier:		Print Name:			
Job Title:		Telephone No:			
NMC No:					
General Practitioner Informed:		Select			
Name of Person Informed:					
Date:		Time:			
Route Information Shared: Verbal	Select	S1/EMIS	Select	Email	Select
Next of Kin Informed:		Select			
Name of Person Informed:					
Date:		Time:			

APPENDIX 4b – For Community use only – Confirmation of fact of death form to be left with the deceased

CONFIRMATION OF FACT OF DEATH v3 2020

TO BE LEFT WITH THE DECEASED FOR FUNERAL DIRECTOR

NAME OF PATIENT	
ADDRESS	
DATE OF BIRTH	
OWN GP - NAME	
OWN GP- ADDRESS	

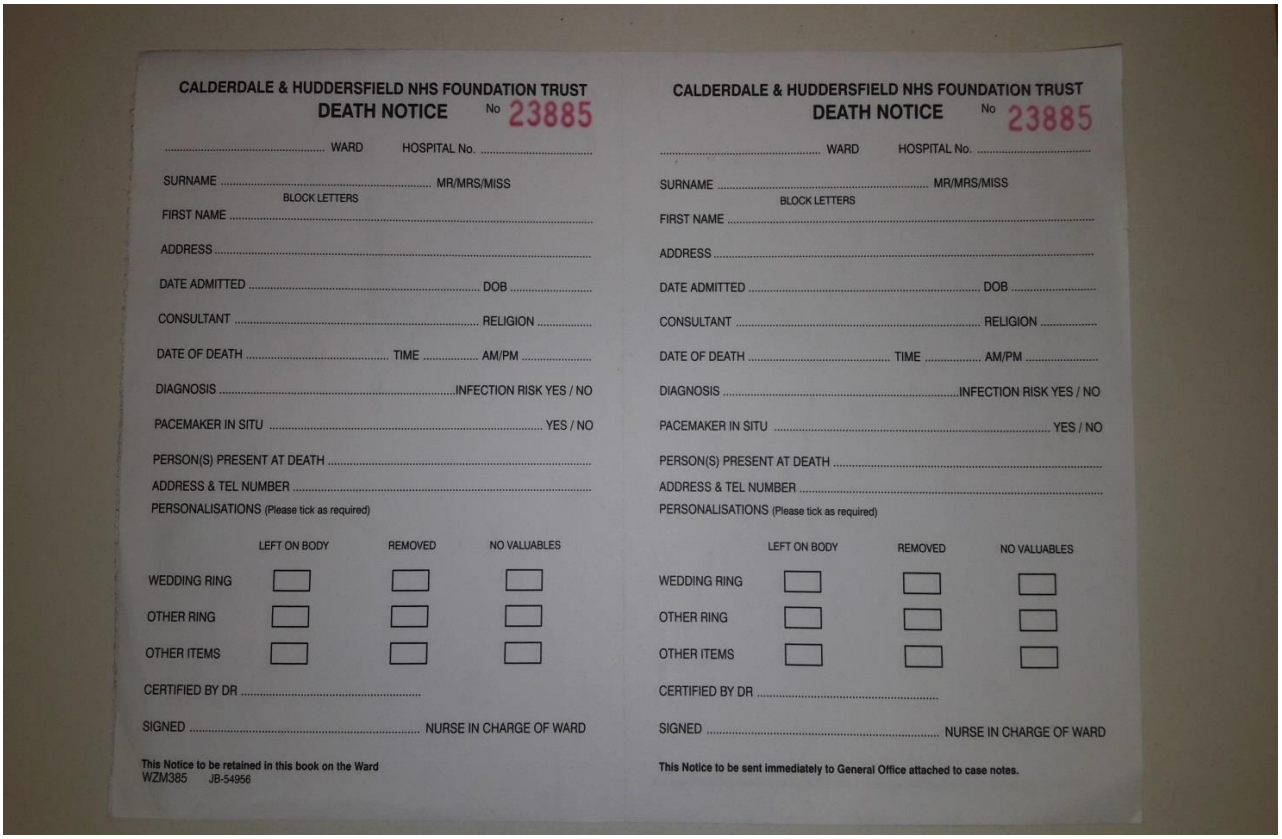
DATE OF CONFIRMATION OF DEATH	
TIME OF CONFIRMATION OF DEATH	
CONFIRMING QUALIFIED NURSE - NAME	
CONFIRMING QUALIFIED NURSE - SIGNATURE	
HAS THE DECEASED SEEN THEIR OWN GP IN THE LAST 28 DAYS	YES / NO
DOES THE PATIENT HAVE ANY IMPLANTABLE DEVICES, e.g. pacemaker or implantable cardioverter defibrillator (ICD)	YES - state type and position NO DON'T KNOW
DOES THE PATIENT HAVE ANY INFECTION	YES - state type NO
Name and address of funeral director to be used (if known) –	
Is the deceased for cremation? YES NO Don't Know	

THIS IS NOT A DEATH CERTIFICATE

Death certificates are obtained via the patient's own GP.

APPENDIX 5

For Hospital use only - Death Notification form



CALDERDALE & HUDDERSFIELD NHS FOUNDATION TRUST
DEATH NOTICE No 23885

..... WARD HOSPITAL No. .....

SURNAME ..... MR/MRS/MISS
BLOCK LETTERS
FIRST NAME .....

ADDRESS .....

DATE ADMITTED ..... DOB .....

CONSULTANT ..... RELIGION .....

DATE OF DEATH ..... TIME ..... AM/PM .....

DIAGNOSIS ..... INFECTION RISK YES / NO

PACEMAKER IN SITU ..... YES / NO

PERSON(S) PRESENT AT DEATH .....

ADDRESS & TEL NUMBER .....

PERSONALISATIONS (Please tick as required)

	LEFT ON BODY	REMOVED	NO VALUABLES
WEDDING RING	☐	☐	☐
OTHER RING	☐	☐	☐
OTHER ITEMS	☐	☐	☐

CERTIFIED BY DR .....

SIGNED ..... NURSE IN CHARGE OF WARD

This Notice to be retained in this book on the Ward
WZM385 JB-54956

CALDERDALE & HUDDERSFIELD NHS FOUNDATION TRUST
DEATH NOTICE No 23885

..... WARD HOSPITAL No. .....

SURNAME ..... MR/MRS/MISS
BLOCK LETTERS
FIRST NAME .....

ADDRESS .....

DATE ADMITTED ..... DOB .....

CONSULTANT ..... RELIGION .....

DATE OF DEATH ..... TIME ..... AM/PM .....

DIAGNOSIS ..... INFECTION RISK YES / NO

PACEMAKER IN SITU ..... YES / NO

PERSON(S) PRESENT AT DEATH .....

ADDRESS & TEL NUMBER .....

PERSONALISATIONS (Please tick as required)

	LEFT ON BODY	REMOVED	NO VALUABLES
WEDDING RING	☐	☐	☐
OTHER RING	☐	☐	☐
OTHER ITEMS	☐	☐	☐

CERTIFIED BY DR .....

SIGNED ..... NURSE IN CHARGE OF WARD

This Notice to be sent immediately to General Office attached to case notes.

APPENDIX 6 – Competency Framework

Theoretical and Clinical competency Assessment for verification of expected death (Adapted from Hospice UK 2022)

Assessment of Competence for Registered Nurse Verification of Expected Adult Death

Name of registered nurse/physician associate:

Name and signature of trainer:

Date of training:

Assessor guidance

- The competencies are a mixture of practical skills, knowledge and understanding.
- All criteria must be achieved during training to achieve competency.
- Registered nurses (RNs)/physician associates (PAs) will self-assess at the completion of the training that they feel competent to perform this skill independently. Competence can be achieved at the first assessment, which can occur as part of the training.
- It is recommended that RNs/PAs reflect on this skill within their clinical practice at least annually during the appraisal process.

	Assessment of Competence	Competent
	Criteria	**YES / NO**
Standard 1: The registered nurse/physician associate is aware of their role and associated guidance		
	Guidance for staff responsible for care after death.	
	Guidance re RN verification of expected adult death.	
Standard 2: The registered nurse/PA is aware of the following definitions		
	Who can recognise a death?	
	Who can verify a death?	
	Who can certify a death?	
	What is an expected death?	
	What is a sudden or unexpected death?	
	Individualised agreement to DNACPR documented in the clinical notes.	
	What is the definition of the official time of death?	

	Assessment of Competence	Competent
	Criteria	**YES / NO**
	Deaths requiring coroner involvement, *noting COVID-19.*	
	Notification of infectious diseases, *noting COVID-19.*	
Standard 3: The registered nurse is aware of the medical and nursing responsibilities		
	The medical responsibilities.	
	The nursing responsibilities.	
Standard 4: The registered nurse/physician associate understands the procedure for verification of a patient's death		
	Risk assessment of PPE and equipment requirement prior to attending the bedside, or home.	
	Demonstrates universal infection control precautions, appropriate donning of PPE, equipment decontamination, and correct hand hygiene procedure, and in the correct sequence. *Note precautions relating to COVID-19.*	
	The patient is identifiable from available documents.	
	There is a completed DNACPR form, or equivalent. Where there is not a DNACPR form, demonstrate clear clinical rationale that the death is irreversible.	

	Infections, implantable devices, and radioactive implants are identified, for example, from the medical notes.	
	Where applicable, a window is opened for ventilation.	
	To instigate the process for deactivation of Implantable Cardiac Defibrillator, if not already deactivated.	
	Stethoscope and pen torch are placed on the clean disposable sheet ready for use.	
Standard 5: The registered nurse/Physician associate is able to follow the procedure and carry out a patient examination to verify death		
	Position the patient for examination and verification of the fact of death.	

	Assessment of Competence	Competent
	Criteria	**YES / NO**
	Knows what to do with tubes, lines, drains, patches and pumps.	
	Knows that if the patient has COVID-19 or is suspected of COVID19 that a face mask is placed over the patient's mouth prior to any movement / positioning.	
	Understands that the patient must be observed for a minimum of five minutes to establish that irreversible cardio-respiratory arrest has occurred.	
	Ensures absence of heart sounds on auscultation.	
	Ensures both eyes are tested for the absence of pupillary response to light.	
	Ensures absence of respiratory effort by observation over the five minutes.	
	Ensures absence of a central pulse on palpation.	
	Ensures that after five minutes of continued cardio-respiratory arrest the absence of motor response to trapezius squeeze is tested.	
	Ensures that any spontaneous return of cardiac or respiratory activity during this period of observation would prompt a further five minutes observations.	
	Ensure stethoscope and pen torch are placed on the sheet ready for cleaning.	
	Demonstrates universal infection control precautions by correctly doffing first set of gloves, performing hand hygiene, and donning second set of gloves to clean stethoscope and pen torch.	
	Knows how to correctly label the deceased for identification.	
	Demonstrates universal infection control precautions by correctly doffing PPE with correct hand hygiene procedure and knows how to dispose of the waste.	

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Standard 6: The registered nurse/physician associate completes appropriate documentation in a timely way		
	How to complete the local verification of death form.	
	Assessment of Competence	Competent
	Criteria	**YES / NO**
	How to record the time of death.	
	How to notify the doctor.	
Standard 7: The nurse/physician associate knows how to support and provide appropriate information to the bereaved family and friends		
	Understands the potential/actual emotional impact of a bereavement on the family and friends, *noting the impact of COVID-19 at this time*.	
	Can demonstrate how they would support the bereaved at the time of death.	
	Understand the potential / actual emotional impact on surrounding patients and residents in communal setting, *and in relation to a COVID-19 related death.*	
	Can demonstrate how they would support surrounding patients / residents without breaching confidentiality.	
	Understands the potential/ actual emotional impact of a bereavement for colleagues and paid carers.	
	Can demonstrate how they would support colleagues and paid carers, *including in a COVID-19 related death.*	
	Knows the support information available for bereaved family and friends.	
	Knows how to signpost relatives to where to collect paperwork and the next steps.	

Competency statement

I…….… (Name) feel competent to perform RNVoEAD unsupervised.

Signed……. Designation……... Date…….