UNIQUE IDENTIFIER NO: C-93-2015
Review Date: January 2018
Review Lead: Specialist Palliative Care Nurse

Calderdale and Huddersfield NHS
NHS Foundation Trust

An Organisational Policy
Verification of Adult Expected Death for Registered Nurses

Version 1

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 Summary Table		
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Consultation Committees		
Committee Name	**Committee Chair**	**Date**
Nursing and Midwifery Committee	Director of Nursing	January 2015
Other Stakeholders Consulted		
Speciality Doctor Medicine for the Elderly – Bryony Greenwood		January 2015
Deputy Director of Nursing		January 2015
Coroner – Martin Fleming and Dominic Bell		January 2015

Does this document map to other Regulator requirements?	
NMC	The Code: Standards of Conduct, Performance and Ethics for Nurses and Midwives (2008)
Health and Social Care Act (2008)	Regulation 7 – outcome 25 Regulation 9 – outcome 4 Regulation 11 – outcome 7 Regulation 13 – outcome 9 Regulation 17 – outcome 1 Regulation 20 – outcome 21

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.

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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 (GPs) 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".

Experienced registered nurses with the necessary training and competencies working within this policy have the authority to verify the fact of death, notify relatives and arrange for the removal of the body.

2. Purpose

Registered nurses 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 (DH 2008) recommends nurse verification of death to improve the quality of care.

Current practice often involves the nurse 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; this distress can be increased if the patient has a parenteral medication infusion for symptom relief. Disconnection of such a device prior to verification has legal implications.

The ability for registered nurses to verify an expected death, will enhance the care of the patient, their family and carers; making best use of resources, with care being delivered in a timely manner by the most appropriate person.

This policy has been developed to support patient/carer choice in the verification of death and in some cases their preferred choice might be for a doctor to attend the patient. In this case the nurse would contact the doctor, or Out Of Hours (OOH) service in the usual way.

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, it is still necessary for a doctor to complete a medical certificate of the cause of death.

3. Duties (Roles and Responsibilities)

Duties within the Organisation

This policy applies to registered nurses employed by CHFT, Locala and Overgate Hospice, whose role involves providing end of life care to patients that have completed the approved training and competency programme.

ROLE OF THE MEDICAL PRACTITIONER

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 from undertaking the process.

The doctor in discussion with the nursing staff will agree that further intervention would be inappropriate and death is expected to be imminent. This will be documented in the patient's clinical records in the home and in the medical notes in the hospital. Wherever possible the relative should be made aware of the patients deteriorating condition and of the plan of care.

A Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR, see appendix 1) form must be completed and in place for these specific patients.

The patients Dr will have been attending regularly to provide medical support and will have visited within the last 14 days.

Issue the death certificate at the first reasonable opportunity 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 is required

ROLE OF THE REGISTERED NURSE

Patient has been discussed with GP and community nursing team and it has been recognised that they are now palliative. The following **documentation should now be in place to ensure this is an expected death.**

Documentation

- Is on Gold standards Framework and been discussed at GSF meetings
- Is clearly documented on IT systems such as system 1 and EMIS that the patient is now palliative
- Is documented in the patient clinical records in the home and in the medical notes in the hospital, that this patient is now palliative
- DNACPR form is in place
- Individualised Care of the Dying Document (ICODD) - though the above is sufficient until the ICODD is being used in the community settings

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.

The patient's death has been identified by a medical practitioner as imminent and further intervention would be inappropriate and a valid DNACPR form is in place.

Verification of Death is only to be undertaken by a First Level Registered Nurse with current NMC Registration who has undertaken appropriate verification of death training and has been assessed as being competent in the knowledge and skills required for safe and effective practice (NMC 2012).

Ensure the relatives/carers understand and accept the verification of death will be undertaken by the nurse and not a doctor. Respect their wishes if they request the procedure to be carried out by a doctor.

A Registered Nurse must not verify death of a person, when any circumstance surrounding the death is unclear or suspicious, or if the cause of death is reportable to the Coroner**.**

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

Verification of death must be done before Personal Cares after Death commence.

Personal Cares after Death relates to the care given to a deceased person after death and the nurse must ensure the process demonstrates respect for the deceased and is focused on respecting their religious and cultural beliefs. The wishes of the patient and the bereaved may influence practice, however the nurse must ensure care given and the verification of death process undertaken is compliant with legal guidelines and maintain a high regard for health and safety issues (Higgins 2008).

In some circumstances the relatives/carers may need support to contact significant others in order to arrange Personal Cares after Death or practice requested by the culture/religious beliefs of the deceased (e.g. elderly relative with no other close next of kin they can approach for support).

The nurse has responsibility to the deceased patient until the body leaves the clinical environment.

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

4. 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 (1996).

Expected/Predicted Death: For the purpose of this Policy expected/predicted death can be defined as:

- Death following on from a period of terminal illness or deterioration and increasing frailty (due to old age) which has been identified as:
- There is no active intervention to prolong life as it would be futile
- Death will be inevitable in the future, may be days/ weeks or months, the exact time is difficult to predict
- The above documents have been completed
- The patient is known to a Dr and a registered nurse working in the acute or community setting, who have been involved in providing the patients end of life care
- The doctor will be able to issue a medical certificate as to the cause of death

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

Unexpected, Unnatural or Suspicious Death

- This is a death that resulted from an unnatural, unexpected, unusual, or suspicious cause. The police, coroner and doctor must always be informed as soon as possible
- This is where a death is unexpected and there is no explicit advance decision documenting the appropriateness of attempting resuscitation prior to a person suffering cardiac or respiratory arrest, it is presumed that a healthcare professional will make all reasonable efforts to resuscitate the person and call an emergency ambulance

Verification of Death

Verification of death is the process of examining a patient and formally confirming the fact of death, which may be performed by suitably trained personnel, not necessarily doctors (Home Office 2003). There is no legal requirement for a Doctor to verify death (British Medical Association (BMA) 1999).

The following are the recognised clinical signs used when verifying death and all the signs should be apparent before death is verified:

- absence of a carotid pulse over at least one minute
- absence of heart sounds over at least two minutes
- absence of respiratory movements and breath sounds over at least two minutes
- fixed, dilated pupils which do not respond to light
- no response to painful stimuli (e.g. supra orbital pressure for at least 10 seconds, application of pressure medially above the eyebrows)
- Check corneal reflexes

Certification of Death

A registered medical practitioner who has attended a deceased person during his last illness is legally responsible to give a medical certificate of the cause of death "*to the best of his knowledge and belief*" (Births and Deaths Registration Act 1953).

The Coroner

The official responsible for investigating deaths, particularly some of those happening under unusual circumstances, and determining the cause of death.

Advance Decision

Instructions given by individuals specifying what actions should be taken for their health in the event that they are no longer able to make decisions due to illness or incapacity. An Advance Decision (formally known as a living will, advance directive/statement) is one form of leaving instructions for treatment. People may make an advance decision or appoint a proxy under the Mental Capacity Act 2005.

An Advance Decision may be verbal, unless it is refusing life sustaining treatment. In this instance for an Advance Decision to be valid, the circumstances specified have arisen, it must be written, signed by the patient (Or another on behalf of the patient, patient must be present), witnessed and contain the words 'even if life is at risk'. Advance Decisions that refuse life sustaining treatment, which are valid, applicable and written are legal and must be followed by medical and nursing staff concerned.

5. Guidance for the Verification of Expected Death

PROCEDURE FOR VERIFYING EXPECTED DEATH

See flowchart for this procedure.

The clinician should:

- Ensure the patient's records (either in their own home or in the hospital notes) reflect that the death is expected
- Note the circumstances, date and exact time of death where possible

- In the case of clinicians being contacted by relatives and attending as soon as possible after death, time of death should be established as closely as possible from relatives
- Ensure the correct identity of the patient is confirmed
- Explain the verification of death process to the relatives/carers
- Check for clinical signs of death, using a stethoscope and penlight or ophthalmoscope

The following are the recognised clinical signs used when verifying death, all the signs should be apparent before death is verified:

- Absence of a carotid pulse over one minute
- Absence of heart sounds over two minutes
- Absence of respiratory movements and breath sounds over two minutes
- Fixed, dilated pupils (unresponsive to bright lights)
- No response to painful stimuli (Supra orbital pressure)
- Check corneal reflexes

It is essential to identify the patient is an expected death. Refer to the heading documentation to determine which documents are required.

When verifying death the verifying nurse must record in the patient's clinical record and complete a paper copy for the funeral director. The copy for the funeral director is only for community patients (Appendix 3).

- The date of death
- The time of death (ascertained if necessary from relative/carer)
- Identity of any person present at the death or, if the deceased were alone, of the person who found the body
- Time of verification
- 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 (is this the GP or OOHs Doctors)
- The Nurse 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 at weekends 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.

UNEXPECTED DEATHS

Where the death is unexpected and where no explicit advance decision has been made about the appropriateness of attempting resuscitation (i.e. no evidence of a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision/form) on a patient suffering cardiac or respiratory arrest, and the express wishes of the patient are unknown and cannot be ascertained, there should be a presumption that health professionals will make all reasonable* effort to attempt to revive the patient and call an emergency ambulance.

Special consideration must be given to the involvement of the coroner's officer and ascertaining suspicious circumstances when the death is unexpected. It is expected that this policy will be read in conjunction with the Resuscitation Policy and DNACPR Policy to ensure appropriate decision making and advocacy for patients.

MONITORING

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. 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.

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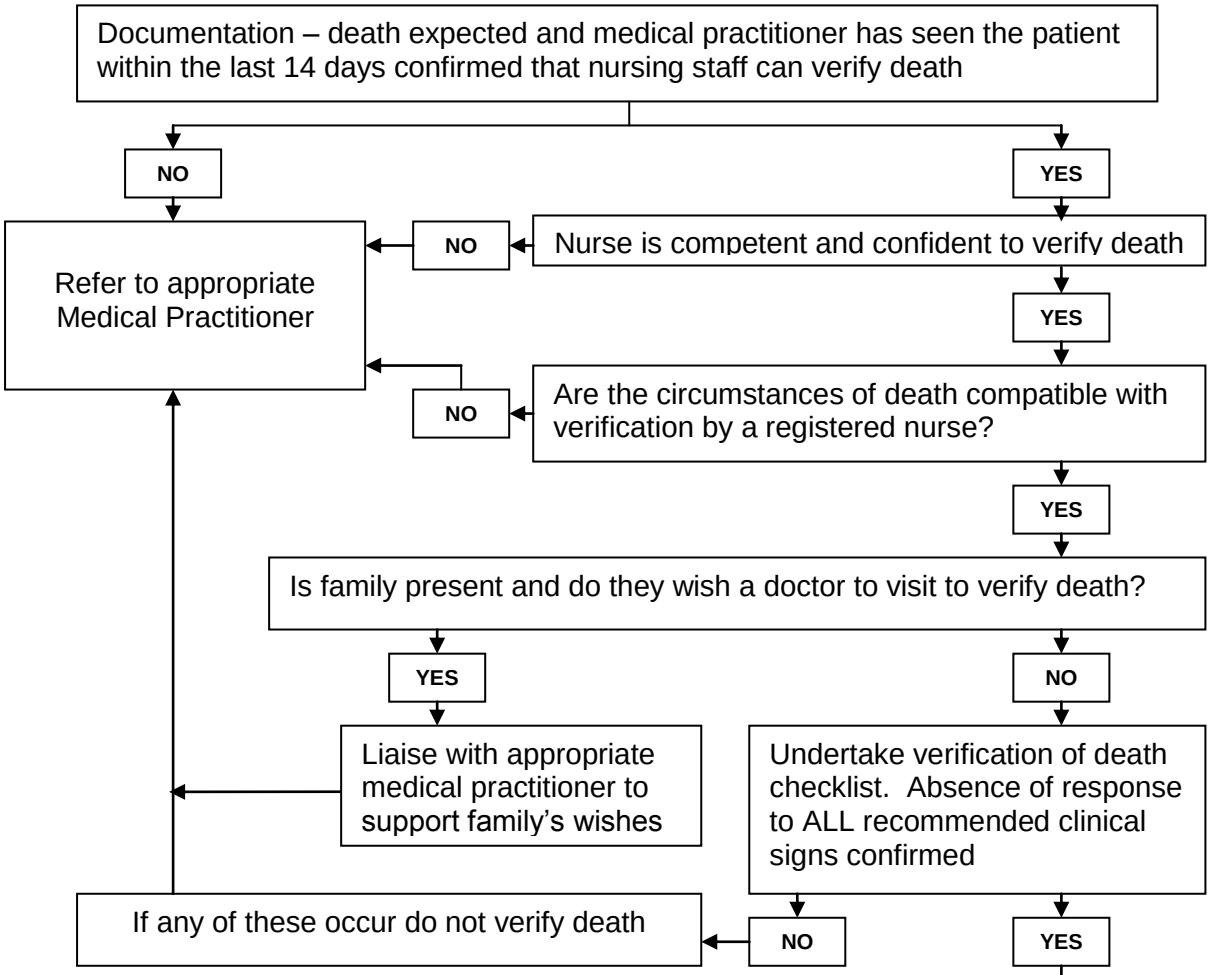
FLOWCHART FOR THE VERIFICATION OF AN EXPECTED DEATH BY A REGISTERED NURSE



Box 1
An expected death:
Where a patient is known to be suffering from a terminal illness, there is no indication that the terminal illness is industrial disease related.
An unexpected death:
Any death not due to terminal illness or a death the family was not expecting.
Where the General Practitioner has not seen the patient in the preceding 14 days.
Where there is any suggestion of suspicious circumstances, trauma, neglect or evidence of industrial disease in an expected death.
If in doubt request a doctor to visit.

6. Consultation, Approval and Ratification Process

Consultation

Consult with Coroner and Police.

7. Reviewing Procedural Document Process

When proposing, and agreeing the review of this document is three years, but the following considerations will be taken into account, a review dates:

- External review requirements
- The likelihood of changes in national or local practice
- The impact of the policy

8. Training and Implementation

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

Applicable when unexpected/sudden death occurs.

Staff will be deemed competent when they have completed the Theoretical and Clinical Competency Assessment for Verification of Expected Death (see appendix 2) and achieved a pass in all applicable areas. They will have this competence verified by a health care professional, who has also been assessed as being competent. All staff should adhere to their Professional Code of Conduct.

See appendix 2 – Theoretical and Clinical Competency Assessment for Verification of Expected Death.

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 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

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. This means verification of death occurs within two hours of confirmed death and removal of the body from the ward occurs within the four hour slot
- The death of a patient is dealt with in accordance with legal requirements
- To follow the Individualised Care of the Dying Pathway or ensure relevant documentation (see heading documentation is in place). The verification of death is in accordance with guidance from regulatory bodies (NMC)
- Registered nurses receive appropriate training to undertake verification of expected deaths
- Consistent approach when verifying death
- Making the most appropriate use of clinical staff's skills and competencies
- The reduction of delays that can lead to increase family distress, particularly when patients may have parenteral medication sited for symptom control
- Prevention of unnecessary emergency ambulance calls where resuscitation would be inappropriate
- Multi-professional collaboration is enhanced for the benefit of service users

LEGAL POSITION

Certification of Death is the process of completing the "Medical Certificate of Cause of Death"; this must be completed by a medical practitioner.

The legal position regarding certification of death is determined by the Births and Deaths Registration Act 1953. The law requires that:

A registered medical practitioner who has attended a deceased person during his last illness is required to give a medical certificate of the cause of death *"to the best of his knowledge and belief"* and to deliver that certificate forthwith to the registrar. The certificate requires the Doctor to state the date on which he saw the deceased person alive and whether or not he has seen the body after death. He is not obliged to view the body, but good practice requires that if he has any doubt about the fact of death, he should satisfy himself in this way (Para 5.01 Report of the Committee on the Death Certification and Coroners, Home Office 1971).

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.

English Law in summary:

- **Does not** require a doctor to confirm that death has occurred
- **Does not** require a doctor to view the body of a deceased person
- **Does not** require a doctor to report the fact that death has occurred

- **Does** require the doctor who attended the deceased during the last illness to issue a certificate detailing cause of death

https://www.gov.uk/after-a-death/when-a-death-is-reported-to-a-coroner

When a Death is reported to a Coroner

A doctor may report the death to a coroner if the:

- Cause of death is unknown
- death was violent or unnatural
- death was sudden and unexplained
- person who died was not visited by a medical practitioner during their final illness
- medical certificate isn't available
- person who died wasn't seen by the doctor who signed the medical certificate within 14 days before death or after they died
- death occurred during an operation or before the person came out of anesthetic
- Medical certificate suggests the death may have been caused by an industrial disease or industrial poisoning (e.g. old or new variant Creutzfeldt-Jakob disease, pneumoconiosis, mesothelioma

9. 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.

10. Monitoring Compliance

Monitoring of this guidance will be the responsibility of clinical leads. A list of competent staff will be maintained at trust level.

11. Associated Documents/Further Reading

Coroners, post-mortems and inquests: Directgov – Government, citizens and rights

http://www.direct.gov.uk/en/Governmentcitizensandrights/Death/WhatToDoAfterADeath/DG_066713

Advance Decisions to Refuse Treatment, a guide for health and social care professionals. London: Department of Health

http://www.ncpc.org.uk/download/publications/ADRT.pdf [Accessed 03-06-2009]

Coroners Act 1988 London: Crown Copyright. Coroners Act 1988 (c. 13) [Accessed 12/1/2009]
http://www.opsi.gov.uk/acts/acts1988/ukpga_19880013_en_1 [Accessed 03.06.2009]

Human Rights Act (1998) London: Crown Copyright
http://www.opsi.gov.uk/acts1998/ukpga_19980042_en_1 [Accessed 03.06.2009]

Mental Capacity Act (2005) London: Crown Copyright.
http://www.opsi.gov.uk/acts/acts2005/ukpga_20050009_en_1 [Accessed 03.06.2009]

Resuscitation Council UK (2007) Decisions relating to cardiopulmonary resuscitation; a joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing. RC (UK)
http://www.resus.org.uk/pages/dnar.pdf [Accessed 03.06.2009]

Royal College of Physicians (2009) Advance Care Planning London: Royal College of Physicians
http://www.rcplondon.ac.uk/pubs/contents/9c95f6ea-c57e-4db8-bd98-fc12ba31c8fe.pdf [Accessed 03.06.2009]

Resuscitation Council (UK) 2005 Resuscitation Guidelines
http://www.resus.org.uk/pages/guide.htm [Accessed 01.12.2005]

NMC (2012) Confirmation of Death for Registered Nurses
Referred to on page 8

Oxford English Reference Dictionary (2nd Edition) 1996, Oxford University Press
Referenced on page 4

12. References

Higgins D (2008) carrying out Last Offices Part 1 – Preparing for the Procedure: Nursing Times V 104: no 37 September 2008 pp 20-21

NMC 2008, The Code of Professional Conduct, Nursing and Midwifery Council
http://www.nmc-uk.org/aFrameDisplay.aspx?DocumentID=3954

NMC 2012, NMC Advice, Verification of Death
http://www.nmc-uk.org/aFrameDisplay.aspx?DocumentID=4020

H:\System\verification of death\Policies\Existing policies\NMC Guidance\Confirmation of death for registered nurses Nursing and Midwifery Council.htm
Referred to on page 8

The Joint Royal Colleges Ambulance Liaison Committee (JRCALC 2006)
http://www2.warwick.ac.uk/fac/med/research/hsri/emergencycare/prehospital/jrcalcstakeholderwebsite/guidelines

The Shipman Inquiry, 2003, Third Report – Death Certification and the Investigation of Deaths by Coroners, Command Paper Cm 5854
http://www.the-shipman-inquiry.org.uk/home.asp

Clinicians have a professional duty to report deaths to the Coroner and should be guided by local practice as to the circumstances in which to do so. However, deaths should always be reported where the deceased dies a violent or unnatural death, the cause death is unknown, or the deceased died while in custody or otherwise in stat detention.

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Appendix 1

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: ……

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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 2017
Regional Lead Contact: Palliative Medicine Consultant
Calderdale & Huddersfield NHS Foundation Trust, West Yorkshire

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Envelope which holds the DNACPR Form

This envelope contains important medical information about

……

The above patient should carry it at all times and bring it to the attention of any Health Professionals, including Ambulance staff

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Appendix 2

Theoretical and Clinical competency
Assessment for verification of expected death

Theoretical and Clinical competency Assessment for verification of expected death.		**PASS**	**REFER**	**COMMENTS**
1.	Discuss the legal and NMC aspects of certification of death and the role of the nurse in verification of expected death.			
2.	Differentiate between expected and unexpected death.			
3.	Recognise when it is not appropriate for a nurse to verify death			
Procedure				
4.	Feel for carotid pulse for one minute			
5.	Listen for heart sounds using a stethoscope for two minutes			
6.	Observe chest for respiratory effort			
7.	Listen for respiratory sounds using a stethoscope for two minutes			
8.	Observe that both pupils are fixed, dilated and not reacting to light using a pen torch.			
9.	Check for corneal reflexes			
10.	Apply supra orbital pressure (pressure to the eyebrow) for at least 10 seconds			

Post procedure		**PASS**	**REFER**	**COMMENTS**
11.	Ensure patient assessment and care after death carried out in a dignified, respectful and timely manner			
12.	Demonstrate accurate, timely and sensitive notification of death			
13.	Complete documentation – verification of death form, patient records, electronic patient records			
14.	Notify appropriate staff and external agencies.			

For community staff only

Appendix 3

VERIFICATION OF DEATH BY NURSE CHECK LIST

Patient's Full Name……..

NHS Number…….Date of Birth……

Address……

Date of death……Time of death……

Patients identity confirmed by……

Patient's home address ……Postcode……

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

Circulatory		**Respiratory**		**Cerebral**	
Carotid pulse absent (feeling for 1 minute)		No respiratory effort by observing the chest		Both pupils fixed, dilated and not reacting to light from pen torch. Check corneal reflexes	
Heart sounds absent (Listening for two minutes)		Respiratory sounds absent (using a stethoscope to listen for two minutes)		No response to painful stimuli – pressure applied to the supra-orbital ridge (just below eyebrow) for 10 seconds.	

Time of verification of death: (24 hour clock) _____ **Date:** _____

Signature of verifier: _____ **Print name:** _____

Job title: _____ **Telephone number:** _____

NMC no……..

General Practitioner informed *(delete as appropriate)*

Name of person informed ……...Date…… Time …….

Route information shared: Fax / verbal / SystmOne *(delete as appropriate)*

Next of kin informed (if not present)

Name of person informed …… Date…… Time …….