

VERIFICATION OF AN EXPECTED ADULT DEATH BY REGISTERED NURSES POLICY

		POLICY
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	YES	NO
	X	
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Author (Position & Name)	Macmillan Lead Nurse End of Life, Debra Elleston. (Reviewed July 2021 by Melanie Butcher, Macmillan End of Life Team Clinical Nurse Specialist)	
Lead Division/ Directorate	Corporate	
Lead Specialty/ Service/ Department	Nursing – End of Life Care	
Position of Person able to provide Further Guidance/Information	Macmillan Lead Nurse for End of Life Care and Macmillan End of Life Team Clinical Nurse Specialist	
Associated Documents/ Information		Date Associated Documents/ Information was reviewed
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1.0 INTRODUCTION

This policy identifies best practice for Registered Nurses in verifying expected deaths within Sherwood Forest Hospitals Foundation Trust (SFHFT). It has been developed in recognition of changing service needs, the need to comply with junior doctors working time directives and the professional development of nurses. In accordance with the Priorities of Care for the Dying Person (Leadership Alliance for the Care of Dying People 2015) and NICE guidance (2017) on care of dying adults in the last days of life, it is appropriate for Registered Nurses to be able to formally verify the expected death of patients, and thus improve the quality of care to families at this difficult time.

Confirming that death has occurred is an important part of the grieving process for relatives and carers. The ability of the Registered Nurse to confirm the inevitable expected death of a patient and also to provide appropriate aftercare to relatives and carers will provide continuity at a time of stress and anxiety.

Registered Nurses may only confirm death on adult patients who have been identified as being expected to die and whose medical notes contain a completed Allow Natural Death (AND) status form and/or completed Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) Form.

English law does not require a doctor to verify or to review the body of a deceased person. The Law does, however, require that the doctor who attended the deceased during their last illness, issues a death certificate with details of the cause of death. Certification should occur within 24 hours or the next working day, except at weekends and bank holidays when the certificate should be produced on the next working day.

SFHFT has agreed that **Registered Nurses, qualified for at least 2 years**, who have received training and assessed as competent, are permitted to perform the role of verifying the death of adult patients in cases when the patient's death is expected. For the purpose of this policy a Registered Nurse is a person who has been qualified for at least 2 years and holds current nursing registration with the United Kingdom regulatory authority for nursing and midwifery, the Nursing and Midwifery Council (NMC).

2.0 POLICY STATEMENT

The aim of this policy is to ensure that expected adult deaths are confirmed by a competent Registered Nurse and comply with legal requirements.

This clinical document applies to:

Staff group(s)

- Registered Nurses who have been qualified for at least 2 years, have received training and are assessed as competent

Clinical area(s)

- All adult in-patient wards; assessment areas; emergency department
- All hospital sites: King's Mill Hospital; Mansfield Community Hospital; Newark Hospital

Patient group(s)

- Adults only

Exclusions

Registered nurses will **not** verify death in the following circumstances:

- Unexpected, suspicious or sudden deaths
- Any reason to suspect that the cause of death is not the expected cause of death
- Death of a person under 18 years of age
- Death of a person who has had surgery or post invasive procedure
- Deaths following an untoward incident, fall, drug error or recent accident
- When the deceased was detained under the Mental Health Act (this is regarded as a ‘death in custody’)
- Where the process of Organ Donation has been commenced

3.0 DEFINITIONS/ ABBREVIATIONS

Trust/SFHFT	Sherwood Forest Hospitals NHS Foundation Trust
Staff:	All employers of the Trust including those managed by a third party on behalf of the Trust
LDOL:	Last Days of Life
Adult:	A person 18 years of age or older
EOLC:	End of Life Care
AND	Allow Natural Death
RN	Registered Nurse
MCCD	Medical Certificate of Cause of Death
Post Invasive Procedure	After a procedure that; makes a cut or hole to gain access to patient’s body or; gains access to a body cavity without requiring a cut or; use of electromagnetic radiation.
OLM	Organisational Learning and Management System
PPE	Personal Protective Equipment

Verification is distinct from certification and clear definitions are as follows:

Verification of death is defined as ‘pronouncing death’ or ‘confirming death’ and is the procedure of determining whether a person is actually deceased.

Certification of death is the process of completing the “Medical Certificate of Cause of Death”. From a legal perspective the following statement applies:

“...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 that the doctor state the last date on which he saw the deceased person alive, and whether or not he saw the body after death” (Home Office, 1971).

From the above statement, it can be assumed that the certifying doctor is not obliged to view the body, but good practice requires that if he/she has any doubt about the fact of death, viewing the body will be necessary.

Expected death is defined when discussions have taken place between the medical & nursing team, where possible the patient & the patient's relatives, and the decision has been made that the patient is recognised as dying. This is then clearly documented in the medical notes and the Last Days of Life Individualised Care Plan should be initiated. The patient should have been seen within the last 14 days of life by a doctor.

It is not sufficient to assume that the death is "expected" because there is a "Do Not Resuscitate" or AND order written in the medical notes.

4.0 ROLES AND RESPONSIBILITIES

Divisional General Managers, Service Line Managers, Matrons and Heads of Nursing should:

- Ensure that the policy is followed within clinical areas.
- Ensure that staff are supported to meet training needs.
- Ensure that staff have access to the Last Days of Life supporting documentation.

Line Managers should:

- Ensure that staff access appropriate training.
- Implement the policy in their department area.
- Investigate incidents/concerns/complaints in relation to this policy.

Registered Nurses should:

- Be qualified for at least 2 years to undertake this role
- Attend appropriate training sessions.
- Maintain their skills and competence to verify expected death of patients within the parameters stated in this policy.
- Accept accountability for their own practice in line with The Code (NMC, 2018).
- Inform the relatives of the patient's death and document this in the nursing documentation. If the expected death occurs during the night, the nurse in charge of the ward must inform the medical team at 09:00 the following morning. Nurse confirmation of expected death does not negate the normal legal requirements relating to the signing of death certificates by medical practitioners (Certification of Death).
- Complete the Infection Control Notification Form if the patient's body is a potential source of infection in line with Trust policy.
- Participate in the investigation of incidents / concerns / complaints regarding registered nurses fulfilment of this policy.
- Report incidents and near misses relating to verification of death.
- Cooperate with pertinent audits of practice within the clinical setting.

Medical Practitioners are:

- Responsible for the Certification of the patient's death
- Responsible for informing the Coroner, where appropriate

5.0 APPROVAL

This policy has been approved by Trust's Documentation Group.

6.0 DOCUMENT REQUIREMENTS (NARRATIVE)

6.1 NURSING RESPONSIBILITIES

Nurses undertaking this procedure must work within the accountability framework laid down by the Nursing and Midwifery Council in the NMC Code of Professional Conduct (NMC, 2018).

They must have read and understood this policy and received appropriate training on the clinical signs of death before undertaking verification of expected death.

The nurse will document and communicate the relevant information regarding the verification process including the patient details, date and time of verification of death.

The nurse should check the deceased patient's notes and the next of kin's details to ensure the correct relatives are contacted and informed of the death.

Since the death is expected and the relatives/next of kin/contact persons should have been involved in the decision-making process, they may choose not to be contacted in the event of death, particularly during the night. The time that the relative/next of kin/contact person wishes to be informed of the death must also be recorded and adhered to. The nurse should ensure that this need is clearly communicated to all members of the nursing team and documented in the patient's records.

Nurses should also be aware of any specific cultural or religious needs or wishes and endeavour to take account of them. Note that for certain religions, it is not acceptable to touch the deceased person with bare hands (see Care After Death policy).

6.2 PROCEDURE FOR THE VERIFICATION OF DEATH BY A REGISTERED NURSE

ACTION	RATIONALE
<p>1. At the beginning of each shift, the Registered Nurse that is responsible for verifying the expected death of a patient will be identified and this will be communicated to the rest of the care team on that shift.</p> <p>Following a death, the nurse must determine if the patient's death was expected and that the circumstances are compatible with nurse verification of death guidance</p>	<p>To ensure an appropriate Registered Nurse is identified to verify the death, ensure good communication and advance planning</p> <p>The death must have been the result of a natural process and there should be documentary evidence that the patient's death is expected e.g. the patient is terminally ill and/or has a Last Days of Life (LDOL) Care Plan in place</p>
<p>2. The nurse verifying death must have completed additional training and be competent and confident to perform the procedure.</p>	<p>A Registered Nurse who has undertaken a programme of training which has given them the knowledge and skills to carry out this extended role and who can provide evidence of this may undertake this procedure (DHSSPS 2008; NMC 2018)</p>

<p>3. Personal Protection Equipment (PPE) must be utilised when completing verification for any patients who are deemed infectious.</p>	<p>The RN verifying the expected adult death should undertake a risk assessment with regards to all PPE selection in accordance with Infection control guidance</p>
<p>4. If family members are present, explain the procedure to them. Relatives may wish to leave the bedside until the procedure is complete.</p> <p>If relatives wish to stay, carry out the procedure in a sensitive and dignified way.</p>	<p>The feelings and wishes of the family should be explored and respected. They should be given appropriate explanation of the process of determining death in a sympathetic, timely and appropriate fashion by those concerned with the management of the patient (AMORC 2008; NMC 2015)</p>
<p>5. Verification of death should occur within one hour of death and by examining all of the following systems:</p> <p>i). Cessation of circulatory system No pulses on palpation verified by absence of carotid pulse after palpation for a minimum of 1 minute</p> <p>No heart sounds verified by listening for heart sounds using a stethoscope for a minimum of 1 minute</p> <p>ii). Cessation of respiratory system No respiratory effort observed No breath sounds verified by observation and listening with a stethoscope for a minimum of 1 minute</p> <p>iii). Cessation of cerebral function Pupils fixed, dilated and not reacting to light verified by shining torchlight into a patients eyes and observing for any change in pupil size or shape. This should be repeated in both eyes No reaction to painful stimuli verified by rubbing the sternum for 10 seconds (the need to perform this in a sensitive manner must be acknowledged and fully explained if loved ones are present)</p>	<p>Timely verification of death is achieved in accordance with best practice</p> <p>In order to verify life extinct, cessation of circulatory and respiratory symptoms and cerebral function must be confirmed.</p>
<p>6. The verification procedure must be documented in the patient's medical notes by the Nurse verifying the death. Nurses should also document that this has been completed in the nursing care plan.</p>	<p>To comply with legal obligations, ensure good record keeping and communication.</p>
<p>7. Report the death to the medical practitioner responsible for the patients care so that the Medical Certificate of Cause of Death can be issued as soon as practical</p>	<p>Only a doctor can issue the Medical Certificate of Cause of Death (DHSSPS 2019). It is good practice to ensure the MCCD is issued within one working day so burial or cremation arrangements are not unduly delayed.</p>

<p>8. Offer support and condolence to the family. Allow the family to have time with the patient as they wish.</p>	<p>Provides the family with an opportunity to reflect and closure.</p>
<p>9. Ensure that the family are provided with verbal and written information and what will happen after death. The Trust's booklet "Information for those who are bereaved" contains this information and should be offered to relatives of the deceased.</p>	<p>To provide clear guidance, support and communication.</p>
<p>10. Personal Care After Death (last offices) as per local policy should be carried out within two to four hours of the person dying.</p>	<p>In order to preserve their appearance, condition and dignity. It is important to note that the body's core temperature will take time to lower and therefore refrigeration within four hours of the death is optimum.</p>

REFERRAL TO THE CORONER

Referral to the coroner for post-mortem examination is not a contra-indication to nursing staff verifying death. However, it should be recorded in the medical and nursing notes that the post-mortem will take place following the death of the patient.

Even when death is expected, there can still be unusual or suspicious circumstances surrounding the death. The coroner for Nottinghamshire, is concerned about ***what happens to the body*** after verification of death in the event of **ANY suspicious or unusual circumstances**. If there are **ANY** suspicious or unusual circumstances, a medical practitioner must be informed and verify the death; if this is out of hours at Mansfield Community Hospital, NEMS need to be informed to come and verify the person's death.

7.0 MONITORING COMPLIANCE AND EFFECTIVENESS

Minimum Requirement to be Monitored (WHAT – element of compliance or effectiveness within the document will be monitored)	Responsible Individual (WHO – is going to monitor this element)	Process for Monitoring e.g. Audit (HOW – will this element be monitored (method used))	Frequency of Monitoring (WHEN – will this element be monitored (frequency/ how often))	Responsible Individual or Committee/ Group for Review of Results (WHERE – Which individual/ committee or group will this be reported to, in what format (eg verbal, formal report etc) and by who)
A review of all incidents involving verification of death	Divisional Leads	Incidents will be notified via the Trust's Datix incident reporting procedure and assessed to ensure that appropriate actions are taken to reduce the identified risks	As and when they occur	Nursing, Midwifery & Allied Health Professionals Committee SFHFT General Palliative & End of Life Care Committee
Where serious incidents occur, these will be investigated to identify the root cause	Policy Lead	Incidents will be notified via the Trust's Datix incident reporting procedure and assessed to ensure that appropriate actions are taken to reduce the identified risks	As and when they occur	Nursing, Midwifery & Allied Health Professionals Committee SFHFT General Palliative & End of Life Care Committee
Registered Nurses who have received training and have been assessed as competent are performing this role	Line Manager	Completion of training and recorded on Trusts OLM Reflective discussion at appraisal	One off training Annually	Nursing, Midwifery & Allied Health Professionals Committee SFHFT General Palliative & End of Life Care Committee

8.0 TRAINING AND IMPLEMENTATION

Registered Nurses who are verifying expected deaths must have:

- Completed the Trust's verification of death training.
- Undertaken a reflective discussion and competence assessment with a senior nurse
- Evidence of attendance or completion of the training that will be sent to the OLM Administration Officer: Training, Education and Development Department, King's Mill Hospital.

9.0 IMPACT ASSESSMENTS

- This document has been subject to an Equality Impact Assessment, see completed form at [Appendix A](#)
- This document has been subject to an Environmental Impact Assessment, see completed form at [Appendix B](#)

10.0 EVIDENCE BASE AND RELATED SFHFT DOCUMENTS

REFERENCES

Academy of Medical Royal Colleges (AOMRC) (2008) A Code of Practice for the Diagnosis and Confirmation of Death. London: AOMRC.

http://aomrc.org.uk/wp-content/uploads/2016/04/Code_Practice_Confirmation_Diagnosis_Death_1008-4.pdf

BMA Confirmation and Certification of Death 2016 available at

<http://www.bma.org.uk/support-at-work/gp-practices/service-provision/confirmation-and-certification-of-death>

Department of Health, Social Security and Public Safety (DHSSPS) (2019) Verifying and Recording Life extinct by appropriate professionals. Circular HSS (MD) 8/2008. Belfast: DHSSPS.

<https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/hss-md-8-2008.pdf>

Department of Health, Social Security and Public Safety (DHSSPS), Coroners Service for Northern Ireland, General Register Office (2008) Guidance on Death, Stillbirth and Cremation Certification. Belfast: DHSSPS.

<http://www.ihrdni.org/315-008.pdf>

Home Office (1971) HO 375 - Report of the Committee of Death Certification and Coroners (Brodrick Committee) Minutes and papers (Cmnd 4810). London: HMSO.

Hospice UK and National Nurse Consultant Group (2015) Care after death: Guidance for staff responsible for care after death. 2nd ed. London: Hospice UK. PDF attached to email

Hospice UK and national Nurse Consultant Group (2021) Special Edition of Care After Death: Registered Nurse Verification of Expected Adult Death (RNVoEAD) Guidance [rnvoead-special-covid-19-edition-final_2.pdf \(hospiceuk.org\)](https://www.hospiceuk.org/rnvoead-special-covid-19-edition-final_2.pdf)

Hospice UK (2017) Care After Death: Registered Nurse Verification of Expected Adult Death (RNVoEAD) guidance London: Hospice UK.

NICE (2017) Care of dying adults in the last days of life [NG31]
<https://www.nice.org.uk/guidance/ng31>

NICE (updated 2017) End of life care for Adults [QS13]
<https://www.nice.org.uk/guidance/qs13>

Nursing and Midwifery Council (NMC) (2018) The code: professional standards of practice and behaviour for nurses and midwives. London: NMC.
<https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf>

Nottinghamshire Healthcare NHS Foundation Trust/Nottingham CityCare Partnership/Nottingham University Hospitals NHS Trust/NHS Bassetlaw CCG/Sherwood Forest Hospitals NHS Foundation Trust (2020) The Nottinghamshire guideline for care in the last year of life: a guide for professionals, p.16 Care after death. Nottingham: Nottinghamshire Healthcare NHS Foundation Trust
https://www.nottsapc.nhs.uk/media/1078/end_of_life_care_guidance.pdf

RCN. A guide for members on confirmation or verification of death by a Registered Nurse Confirmation or verification of death by registered nurses
<https://www.rcn.org.uk/get-help/rcn-advice/confirmation-of-death>

Secretary of State for the Home Department (2003) Death Certification and Investigation in England, Wales and Northern Ireland – the Report of a Fundamental Review Cm 5831 London: HMSO
<http://webarchive.nationalarchives.gov.uk/20131205105739/http://www.archive2.official-documents.co.uk/document/cm58/5831/5831.pdf>

RELATED SFHFT DOCUMENTS

- Last Days of Life for Adults Policy
- Allow Natural Death (AND) Policy
- Care after Death Policy (replaces Last Offices and includes procedure for the direct release of a deceased patient)
- Referral and Consideration of Adult Deceased Organ and Tissue Donation (Midlands Integrated Care Guide)

11.0 KEYWORDS

Certify; die; dead; End of Life; Certification of death;

12.0 APPENDICES

- [Appendix A](#) – Equality Impact Assessment
- [Appendix B](#) – Environment Impact Assessment

APPENDIX A – EQUALITY IMPACT ASSESSMENT FORM (EQIA)

Name of service/policy/procedure being reviewed: Verification of Adult Expected Death by Registered Nurses Policy			
New or existing service/policy/procedure: Existing			
Date of Assessment: 23 rd July 2021			
For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)			
Protected Characteristic	a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?	b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?	c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality
The area of policy or its implementation being assessed:			
Race and Ethnicity	No	N/A	N/A
Gender	No	N/A	N/A
Age	No	N/A	N/A
Religion	No	N/A	N/A
Disability	No	N/A	N/A
Sexuality	No	N/A	N/A
Pregnancy and Maternity	No	N/A	N/A
Gender Reassignment	No	N/A	N/A
Marriage and Civil Partnership	No	N/A	N/A
Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation)	No	N/A	N/A

<p>What consultation with protected characteristic groups including patient groups have you carried out?</p> <ul style="list-style-type: none"> N/A
<p>What data or information did you use in support of this EqIA?</p> <ul style="list-style-type: none"> N/A
<p>As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments?</p> <ul style="list-style-type: none"> No
<p>Level of impact</p> <p>From the information provided above and following EQIA guidance document Guidance on how to complete an EIA (click here), please indicate the perceived level of impact:</p> <p>Low Level of Impact (<i>Delete as appropriate</i>)</p> <p>For high or medium levels of impact, please forward a copy of this form to the HR Secretaries for inclusion at the next Diversity and Inclusivity meeting.</p>
<p>Name of Responsible Person undertaking this assessment: Melanie Butcher, Macmillan End of Life Team Clinical Nurse Specialist</p>
<p>Signature:</p>
<p>Date: 23rd July 2021</p>

APPENDIX B – ENVIRONMENTAL IMPACT ASSESSMENT

The purpose of an environmental impact assessment is to identify the environmental impact, assess the significance of the consequences and, if required, reduce and mitigate the effect by either, a) amend the policy b) implement mitigating actions.

Area of impact	Environmental Risk/Impacts to consider	Yes/No	Action Taken (where necessary)
Waste and materials	<ul style="list-style-type: none"> • Is the policy encouraging using more materials/supplies? • Is the policy likely to increase the waste produced? • Does the policy fail to utilise opportunities for introduction/replacement of materials that can be recycled? 	No	
Soil/Land	<ul style="list-style-type: none"> • Is the policy likely to promote the use of substances dangerous to the land if released? (e.g. lubricants, liquid chemicals) • Does the policy fail to consider the need to provide adequate containment for these substances? (For example bunded containers, etc.) 	No	
Water	<ul style="list-style-type: none"> • Is the policy likely to result in an increase of water usage? (estimate quantities) • Is the policy likely to result in water being polluted? (e.g. dangerous chemicals being introduced in the water) • Does the policy fail to include a mitigating procedure? (e.g. modify procedure to prevent water from being polluted; polluted water containment for adequate disposal) 	No	
Air	<ul style="list-style-type: none"> • Is the policy likely to result in the introduction of procedures and equipment with resulting emissions to air? (For example use of a furnaces; combustion of fuels, emission or particles to the atmosphere, etc.) • Does the policy fail to include a procedure to mitigate the effects? • Does the policy fail to require compliance with the limits of emission imposed by the relevant regulations? 	No	
Energy	<ul style="list-style-type: none"> • Does the policy result in an increase in energy consumption levels in the Trust? (estimate quantities) 	No	
Nuisances	<ul style="list-style-type: none"> • Would the policy result in the creation of nuisances such as noise or odour (for staff, patients, visitors, neighbours and other relevant stakeholders)? 	No	