



Association for
Palliative Medicine



National
Nurse Consultant Group
Palliative Care



THE
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for **hospice at home**



Royal College
of Nursing



Royal College of
General Practitioners

Care After Death: Registered Nurse Verification of Expected Adult Death (RNVoEAD) guidance

Introduction

The aim of this guideline and the accompanying competency assessment tool (See Appendix 2) is to provide a framework for the timely verification of expected adult deaths by experienced (assessed as competent) registered nurses.¹ It will enable staff to care appropriately for the deceased, in line with local policy, and minimise distress for families and carers following an expected death at any time of the day / night / week. It is in line with the person and family centred care recommended in national documents.²

Timely verification – within one hour in a hospital setting and within four hours in a community setting³ – is an important stage in the grieving process for relatives and carers and also a key time for support.

Families should be advised that there maybe a difference between the time of the last breath and that which is recorded as the time of verification of death in the notes (this is the official time of death). This guidance ensures that the death is dealt with:

- in line with the law and coroner requirements (See Appendix 1)
- in a timely, sensitive and caring manner
- respecting the dignity, religious and cultural needs of the patient and family members.

It ensures the timely removal of the deceased to the mortuary / funeral directors.

It also ensures the health and safety of others are protected, eg from infectious illness, radioactive implants and implantable devices.

Scope of the guidelines

Inclusion criteria:

The guidance applies to registered nurses, 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. This includes when the person has died expectedly from mesothelioma.

- The 'Do not attempt cardio-pulmonary resuscitation' document is signed in line with current guidance.⁴
- There is agreement for Registered Nurse Verification of Expected Death documented clearly in the clinical notes.
- 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).

Exclusion criteria:

None advised.

Definitions

Recognition of death:

It is recognised that relatives, nursing home staff and others can recognise that death has occurred. This will be documented as the time of last observed breath.

Verification of the fact of death:

Verification of the fact of death documents this formally in line with national guidance⁵ and is associated with responsibilities of identification, notification of infectious illnesses, and implantable devices.⁶ This is recognised as the official time of death.

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.

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. In addition a doctor must have seen the patient in the last 14 days.⁷

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 there is a requirement to begin resuscitation (unless the circumstances can be justified).

Sudden or unexpected death within a terminal period:

A patient with a terminal diagnosis can have a sudden death, eg an embolism. Death can be verified by an RN in these circumstances provided the DNACPR form is completed and the Doctor has written in the notes that the RN can verify the death and the circumstances are discussed with the doctor.

Do not attempt cardio-pulmonary resuscitation (DNACPR):

CPR is a medical treatment that endeavours to re-start cardio-respiratory function. The advance decision not to attempt CPR and allow a natural death is underpinned by comprehensive national guidance.⁸

Responsibilities

Medical:

- Doctors will document in the patient's clinical record that an RN can verify the death.
- A DNACPR decision is documented.
- The doctor will be available if necessary to speak to families after death of the patient. This should be arranged at the soonest mutually convenient time.
- The responsible doctor (or if necessary a delegated doctor) will always explain / be available to explain the cause of death they have written on the medical certificate.

Nursing:

- All RNs must have read and understood this guidance and received appropriate training and deemed competent.
- The RN 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 RN carrying out the procedure must notify the funeral director /mortuary of any infections, radioactive implants, implantable devices and whether an implantable cardio-defibrillator is still active.
- It is the right of the verifying nurse to refuse to verify death and to request the attendance of the responsible doctor / police if there is any unusual situation.

Procedure

Equipment (cleaned according to local procedure):

- Pen torch
- Stethoscope
- Watch with second hand

Verification of expected death will require the nurse to assess the patient for a minimum of **FIVE (5) MINUTES** to establish that irreversible cardio respiratory arrest has occurred, as well as specific additional observations.⁹ **Any spontaneous return of cardiac or respiratory activity during this period of observation should prompt further five minutes observations.**

ACTION	RATIONALE
Check written notes that registered medical practitioner has authorized RNVoEAD.	To ensure agreement of process.
Check that the NHS number of patients clinical records and deceased correlate and patient is identified correctly with name band – name, date of birth address or NHS number and that there are two name bands in situ.	To correctly identify deceased.

ACTION	RATIONALE
Identify from clinical notes infectious diseases, radioactive implants, implantable medical devices.	To enable correct information to ensure others involved in the care of the deceased are protected.
Instigate process for deactivation of implantable cardiac defibrillator (ICD) if not already deactivated. ¹⁰	To ensure the timely deactivation of ICD.
Adopt universal infection control precautions.	To ensure protection of RN.
Lie the patient flat. Leave all tubes, lines, drains, medication patches and pumps, etc in situ (switching off flows of medicine and fluid administration if in situ) and spigot off as applicable and explain to those present why these are left.	To ensure the patient is flat ahead of rigour mortis, and all treatments are in situ ahead of verifying death.
Cessation of the circulatory system, ie no carotid (or central) pulse for at least one full minute.	To ensure there are no signs of cardiac output.
Listen to heart sounds with a stethoscope for at least one full minute.	To ensure there are no signs of cardiac output.
Cessation of respiratory system, ie no respiratory effort or no breath sounds. Verified by listening for at least one full minute.	To ensure there are no visible respirations. Any respirations indicate the patient is breathing.
Assessment of cessation of central pulse, cessation of heart sounds and cessation of respiratory effort should total five minutes.	
Cessation of cerebral function. Check that both pupils are fixed (not reacting to light or to any other stimulus) and dilated using a pen torch or ophthalmoscope.	To ensure there is no cerebral activity. Any pupil or eye movements indicate the patient remains having cerebral function.
No reaction to trapezius squeeze.	To ensure no cerebral activity.
The RN verifying the death needs to complete the verification of death form in the clinical notes. Time of death is recorded as when verification of death is completed (ie not when the death is first reported).	For legible documentation and legal requirements.
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 written information about "the next steps".	To ensure the family are supported during this difficult time.

Auditing and monitoring

RNs will be expected to update competency by reflection on practice annually and keep this in their portfolio.

Evidence of audit – both organisational in terms of the processes of care after death including RNVoeAD, and the experience of bereaved relatives in line with national guidance.¹¹

Appendix 1: Deaths requiring coronial investigation

- 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.

More detailed information is available from the Ministry of Justice publication, 'Guide to coroner services'.¹²

Appendix 2: Assessment of competence for Registered Nurse Verification of Expected Death

Name of registered nurse:

Name and signature of trainer:

Date of training:

Date of first clinical assessment:

Name and signature of clinical assessor:

Date of second clinical assessment:

Name and signature of second clinical assessor:

Assessor guidance:

- The competencies are a mixture of practical skills and knowledge and understanding.
- All criteria must be achieved during training to achieve competency ahead of two clinical observations.
- Registered nurses (RNs) will self assess at the completion of the two observed clinical practice that they feel competent to perform this skill independently.
- It is recommended that RNs reflect on this skill within their clinical practice at least annually during the appraisal process.

	Criteria	In training		In observed clinical practice			
		Pass	Fail	Pass	Fail	Pass	Fail
Standard 1: The registered nurse is aware of their role and associated guidance							
	Guidance for staff responsible for care after death						
	Guidance re RN verification of death						
Standard 2: The registered nurse is aware of the following definitions							

		In training		In observed clinical practice			
	Criteria	Pass	Fail	Pass	Fail	Pass	Fail
	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						
	What is a sudden or unexpected death in a terminal period?						
	Indications for DNACPR and the correct completion of documentation.						
	What is the definition of the official time of death						
	Deaths requiring coronial involvement						
Standard 3: The registered nurse is aware of the medical and nursing responsibilities							
	The four medical responsibilities						
	The four nursing responsibilities						
Standard 4: The registered nurse understands the procedure for verification of a patients death							
	There is documented evidence that the medical practitioner has authorised RNVoED, and there is a completed DNACPR form						
	The patient and associated clinical record is correctly identified						
	Infections, implantable devices and radioactive implants are identified from the medical notes						
	To instigate the process for deactivation of implantable cardio defibrillator if not already de-activated						
	For universal infection control precautions						
Standard 5: The registered nurse is able to follow the procedure and carry out a patient examination to verify death							
	How to position the patient for examination and verification of fact of death						

		In training		In observed clinical practice			
	Criteria	Pass	Fail	Pass	Fail	Pass	Fail
	What to do with tubes, lines, drains, patches and pumps						
	To check the carotid pulse for one full minute						
	To monitor heart sounds for one full minute						
	To listen to the chest for at least one full minute, and observe to ensure no respiratory effort.						
	To ensure checks take place over five minutes						
	To check that pupils are fixed and dilated						
	To apply trapezius squeeze						
	That any spontaneous return of cardiorespiratory function, or doubt should prompt an additional five minute observation						
Standard 6: The registered nurse completes appropriate documentation in a timely way							
	How to complete the verification of death form in the clinical notes						
	To record the time of death						
	To notify the doctor						
Standard 7: The nurse know 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						
	Can demonstrate how they would support the bereaved at the time of death						
	Understand the potential / actual impact on surrounding patients and residents in communal setting						
	Can demonstrate how they would support						

		In training		In observed clinical practice			
	Criteria	Pass	Fail	Pass	Fail	Pass	Fail
	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						
	Knows the support and written information available for bereaved family and friends						
	Knows how to signpost relatives to where to collect paperwork / what the next steps are						

Competency statement

I.....(name and designation) feel competent to perform RNVoED unsupervised.

Signed..... Date.....

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- Dr Catherine Millington-Saunders, Royal College of General Practitioners
- Dawne Garrett, Royal College of Nursing
- Anita Hayes, National Council for Palliative Care
- Prof Rob George, Association for Palliative Medicine
- Sharon Blackburn, National Care Forum
- Helen Birch, National Association for Hospice at Home

Hospice UK also consulted with organisations and individuals including:

- Royal College of Pathologists
- HM Senior Coroner for Staffordshire (South)
- Ministry of Justice
- Coroners Society of England and Wales
- Bereavement Coordinator Southern HSC Trust Northern Ireland
- Professor Magi Sque, University of Wolverhampton and the Royal Wolverhampton NHS Trust
- Dr Michael Osborn MRCS FRCPath, Consultant Histopathologist, Imperial College Healthcare NHS Trust
- Dr Alan Fletcher, Consultant Emergency Physician at Sheffield Teaching Hospitals NHS Foundation Trust, Medical Examiner (of the documents and cause of death)

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Published by Hospice UK in January 2017.

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