

<b>Standard Operating Procedure</b>	
Document Type	SOP
Document Name	Nurse Verification of Expected Death by a Registered Nurse Working Within the Community Setting (Community Nursing Service or Nursing Homes)
Version	4.0
Effective From	January 2019
Renewal by	CCICP Community Nurse Team Leader Working Group
Owner	CCICP Head of Nursing
Prepared by	Out of Hours Team leader Nantwich Care Community Service Manager
Approved by	<i>Information Governance Group</i>
Superseded documents	3.0
Relevant regulations/legislation/guidelines	<i>NMC, BMA and Hospice UK</i>

***Please be advised that the Trust discourages the retention of hard copies of policies and procedures and can only guarantee that the policy on the Trust Intranet is the most up to date version***

*(Please be aware that the most recent version of this template is available electronically on the Trust intranet/Frequently Used Forms/Integrated Governance. Please use this template in conjunction with the Trust SOP for Approval of Clinical Guidance Pathways / SOP` s)*

<b>Version Control</b>			
<i>Date</i>	<i>Version Number</i>	<i>Change Details</i>	<i>Approved by</i>
13/06/2018	4.0	<i>Updated reference material, Updated DOLS in line with regulation Removed the need for 2 yearly updates</i>	



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## Procedure Pathway

### 1. INTRODUCTION / PURPOSE

It is the policy of MCHFT and Central Cheshire Integrated Care Partnership (CCICP) that no one will be discriminated against on grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex or sexual orientation. The Trust will provide interpretation services or documentation in other mediums as requested and necessary to ensure natural justice and equality of access.

Within community services there will be those patients whose death becomes inevitable. These are expected Deaths.

In recent years there has been an acknowledgement that a registered general nurse who has undertaken education can perform this role (1). However, certification of death remains the legal responsibility of the patient's General Practitioner (GP).

This policy is designed to provide a safe framework to enable qualified nursing staff to verify expected death within the community. It is also to improve care by reducing the delay between death occurring and verification taking place.

This policy is for patient's dying at home or in a care home setting.

The flow diagram in Appendix 1 illustrates the Nurse Verification of Death process

#### **Verification of Death**

The purpose of verification of death is to determine whether a patient is actually deceased.

All deaths should be subject to professional verification that life has ended.

Verification of death is separate to the certification process and can be performed by a Medical Practitioner or other suitably trained and qualified professional, such as an approved Registered Nurse.

#### **Certification of Cause of Death**

Medical certification of cause of death can only be carried out by a Medical Practitioner as defined by The Birth and Death Registration act 1953 (2). There is no legal requirement for a Medical Practitioner to verify death. The only legal requirement is to issue a death certificate stating the cause of death.

The Medical Practitioner will be responsible for informing the Coroner of reportable deaths, even when the death is expected. These would include deaths due to industrial disease, those related to the patient's employment, or when the patient has had a surgical procedure or significant injury in the twelve months prior to death.

#### **Expected Death**

An expected death is when the patient's death is anticipated to be in the near future and the Doctor will be able to issue a medical certificate as to the cause of death. The Doctor must have seen the patient within the last 14 days prior to death. There must be no concerns regarding the care the patient has received and no requirements for the police to be called.

## **Legal Position**

The law requires that:

“A registered Medical Practitioner who has attended a deceased person during their last illness is required to give a medical certificate stating the cause of death to the best of their knowledge and belief and to deliver that certificate forthwith to the Registrar. The certificate requires that the Medical Practitioner states the last date on which they saw the deceased person alive, and whether or not they saw the body after death”.

“The Medical Practitioner is not obliged to view the body but good practice requires that if they have any doubt about the fact of death, they should satisfy themselves in this way.”(4)

## **2. SCOPE**

**The following conditions apply.**

The policy is for adults only aged 18 years and above.

The patient/patients death has been identified as expected.

There has been a documented discussion and agreement with the GP that when the patient dies the nurse will be able to verify death (see Appendix 4). The GP must have visited the patient in the 14 days prior to death.

The GP should have completed a Nurse Verification of Expected Death form ( Appendix 4) OR the relevant section of the End of Life Care Plan.

If an expected death may be due to an industrial disease or related to the Deceased's employment, for example Asbestosis or Mesothelioma, or when the patient has had a surgical procedure or significant injury in the twelve months prior to death, the nurse may verify the death but the GP will need to refer the death to the coroner.

**The policy does not apply:**

In cases of sudden or expected death.

In cases of an expected death, where the death occurs in an unexpected manner or unexpected circumstances.

Death that has occurred as a result of untoward incident, fall or drug error.

Any unclear or remotely suspicious death.

In these circumstances the police and the Coroner must be informed prior to removal of the body.

## **Clinical Decisions**

When the patient's death has been identified as expected, it is important (if this has not already happened) that communication takes place between medical and nursing staff, patients and their families about clinical decisions (5).

It should be ensured that all decisions are documented and there is patient and family agreement where possible.

**These decisions can include:**

Whether to attempt cardiopulmonary resuscitation and if not ensure a Do Not Attempt Cardiopulmonary resuscitation (DNACPR) lilac form is in place.

Whether treatment ceilings are required (specific decisions on the appropriate levels of treatment for individual patients).

Whether organ/tissue donation is an option.

Whether any implanted cardiac defibrillator should be deactivated as these may be triggered in the dying phase and cause discomfort.

Whether the preferred place of death has been ascertained.

### 3. PROCEDURE

ACTION	RATIONALE
<p>1. The GP and the nurse will identify the patients whose death is expected.</p> <p>GP to sign and complete the appropriate Verification of Death form (see Appendix 4) OR relevant section of the End Of Life Care Plan which will be kept with the patient.</p> <p>In the community setting an alert should be entered on to Emis to acknowledge that the patient has a Nurse Verification form in place.</p> <p>Nurse to record in the patient's notes that death is confirmed as 'expected' by the GP.</p>	<p>1. To ensure good communication between the GP and Nurse and Out of Hours services. To provide documented evidence of discussion.</p>
<p>2. Nurse to ensure that carers/ relatives have contact details for the Community Nursing Service &amp; District Nurse Out of Hours Services.</p>	<p>2. To ensure that the carers/relatives know how to contact the nurse when the patient dies.</p>
<p>3. Nurse to discuss and if appropriate document with carers/relatives any religious, cultural or spiritual requests before death.</p>	<p>3. To respect individual beliefs and wishes.</p>
<p>4. At the time of death equipment required: Pen Torch Watch with second hand Stethoscope</p>	
<p>5. At the time of death the following checks will be required: The individual should be observed by the responsible person for a minimum of 5 minutes to establish that irreversible cardiorespiratory arrest has occurred. Any spontaneous return of cardiac or respiratory activity during this period of observation should prompt a further 5 minutes of observation from the next point of cardiorespiratory arrest. After 5 minutes of continued cardiorespiratory arrest, check the pupil reaction and whether there is any response to the trapezius</p>	<p>4. To comply with AoMRC guidance (2008). (7)</p>

squeeze.	
a) Palpate the carotid pulse for 1 minute	a) Absence of carotid pulse indicates that death has occurred.
b) Listen to heart sounds using a stethoscope.	b) Absence of heart sounds indicates that death has occurred
c) Check the absence of respiratory movement.	c) Absence of respiratory movements indicates that death has occurred.
d) Check the patient's pupil reaction with a pen torch. Pupils should be fixed, dilated and unresponsive to light.	d) Pupils that do not respond to light (fixed and dilated) indicates that death has occurred.
e) Check whether there is any motor response to the trapezia squeeze.	e) Absence of motor response indicates that death has occurred.
f) Confirm to the carers/relatives that the patient has died.	f) To keep the carers/relatives informed.
6. Record the time of death and complete the Verification of Death form (see Appendix 4) OR the relevant section of the End of Life Care Plan.	6. In line with record keeping guidance and to meet legal requirements.
7. Remove any equipment from the patient (i.e. syringe pump, catheter) and document in nursing record.  If removing parenteral medication, document drugs delivered by this route, amount remaining still to be infused and time of disconnection	7. To maintain patients dignity and to minimise distress for carers/relatives.  To maintain accurate record of drugs infused immediately prior to death.
8. Inform the carer/relatives that they should contact funeral director/undertaker, care homes may do this on behalf of relatives .	8. To initiate next steps
9. If death occurs within GP working hours inform GP immediately. If death occurs out of hours contact the GP at the earliest opportunity.	9. To allow GP to decide if they wish to see the body before it goes to the funeral director/undertaker.
10. Inform members of any other relevant service providers/organisations.	10. To maintain good communication with other service providers/organisations.
11. Notify the GP of the death.	11. To inform the GP of the death and the need for certification.



#### 4. RESPONSIBILITIES / DUTIES

##### Medical Responsibilities

Patients whose death is expected will be identified formally by either GP or Medical Practitioner responsible for that patient and a written/electronic record made.

Discussions must include the views of the patient, relatives and nursing staff responsible for the patient.

The decision that death is expected will be documented in the clinical notes using the expected death form (see appendix 4) or within an End of Life Care Plan. This will be signed by the GP.

The GP will communicate with the nursing staff regarding those patients whose death is expected and confirm by the above.

The GP should ensure that the patient is reviewed regularly and at least every 14 days.

If the relatives of a deceased patient wish to speak to a GP, this request should be facilitated.

The responsible GP of the deceased patient will complete the death certificate as soon as practical and within the timeframe required by law.

##### Nursing Responsibilities

Verification of death can only be carried out by those Nurses who have received appropriate training, who have read and understood this policy and have been assessed as competent in identifying clinical signs of death.

All Nurses should adhere to the NMC Code for Nurses and Midwives (2015). (6)

The Nurse who is informed of the medical decision to identify a patient as an expected death must:

Ensure the GP completes the appropriate Nurse Verification of Expected Death Form (Appendix 4) OR the relevant section of the End of Life Care Plan.

Inform the day and out of hours nursing teams.

Ensure that the decision is also clearly documented onto Emis and an alert set up to notify the multidisciplinary team.

The Nurse verifying the death has the responsibility of informing the relevant Medical Practitioner. The Nurse should record the date and time this was carried out on the appropriate Nurse Verification of Expected Death Form (Appendix 4) OR within the relevant section of the End of Life Care Plan.

Where a GP has appropriately completed a Nurse Verification of Expected Death Form within a nursing home setting and the patient meets the identified criteria within this standard operating procedure. In the absence of a suitably trained nurse on duty within the nursing home the Out of Hours Nursing Service can be contacted to undertake verification of death.

### **Implementation**

The NMC code 2015 places specific responsibilities on Nurses to maintain professional knowledge and competence. Nurses are asked to recognise and work within the limits of their competence and complete the necessary training before carrying out a new role.

All registered Nurses verifying death must have the competencies, skills and knowledge to enable them to determine the physiological aspects of death. Nurses must have attended the appropriate theoretical training and be assessed and signed off as competent in practice.

### **PATIENTS WITH SYRINGE PUMPS**

Whilst awaiting verification of death, the syringe pump and contents should be left in place, BUT the battery can be removed being meticulous not to alter settings.

The syringe pump may be removed if the nurse is suitably trained and assessed as competent to Verify Death **AND** has been assured by the patient or referral to coroner.

In the event of an unexpected death or unexpected circumstances the GP should be contacted immediately and everything, including the syringe pump and contents should be left in place untouched.

Unused Controlled drugs should be disposed as per Central Cheshire Integrated Care Partnership (CCICP) Controlled Drugs Policy- Safe and secure handling (2016), or for nurses employed within a nursing home in accordance with their Home's policy.

The current policy will be available on the CCICP intranet and Cheshire Epaige website, (link below)

<http://www.cheshire-epaige.nhs.uk/SitePages/Home.aspx>

**5. ASSOCIATED DOCUMENTS**

List all documents to be read in conjunction with this policy.  
These should be written as a hyperlink rather than added as an appendix

**6. Consultation and Communication with Stakeholders**

Details of the consultation process that was used in the development of the document.  
List ALL the staff members involved in the development or implementation of this document.

**7. MONITORING AND REVIEW**

Standard/process/issue required to be monitored	Monitoring and Audit			
	Process for monitoring e.g. audit	Responsible individual /group	Frequency of monitoring	Responsible committee
1. Duties	Policy review		3 years	

## 9.1 Internal References

- (1). Central Cheshire Integrated Care Partnership (CCICP) . Controlled Drugs Policy- Safe and secure handling (2016)



Controlled\_Drugs\_Po  
licy\_-\_Safe\_and\_Sect

## 9.2 External References

- (1) Confirmation of Death for Registered Nurses. Royal College of Nursing (RCN) 2012.
- (2) Births and Deaths Registration Act 1953.
- (3) British Medical Association (BMA). (2018). Confirmation and Certification of Death – Guidance for GP’s in England and Wales. London BMA.
- (4) HMSO. Home Office (1971). Report of the committee on Death Certification and Coroner. CMND 4810. London. Her Majesty Stationary Office (HMSO).
- (5) Hospice UK. Care After Death. Registered Nurse Verification of expected Adult Death Guidance. (2017)
- (6) The Code for Nurses and Midwives (2015) Nursing and Midwifery Council. (NMC)
- (7) A Code of Practice for the Diagnosis and Confirmation of Death. Academy of Royal Medical Colleges (2008)

## 10 APPROVAL

Approving Committee: CCICP Integrated Governance Group

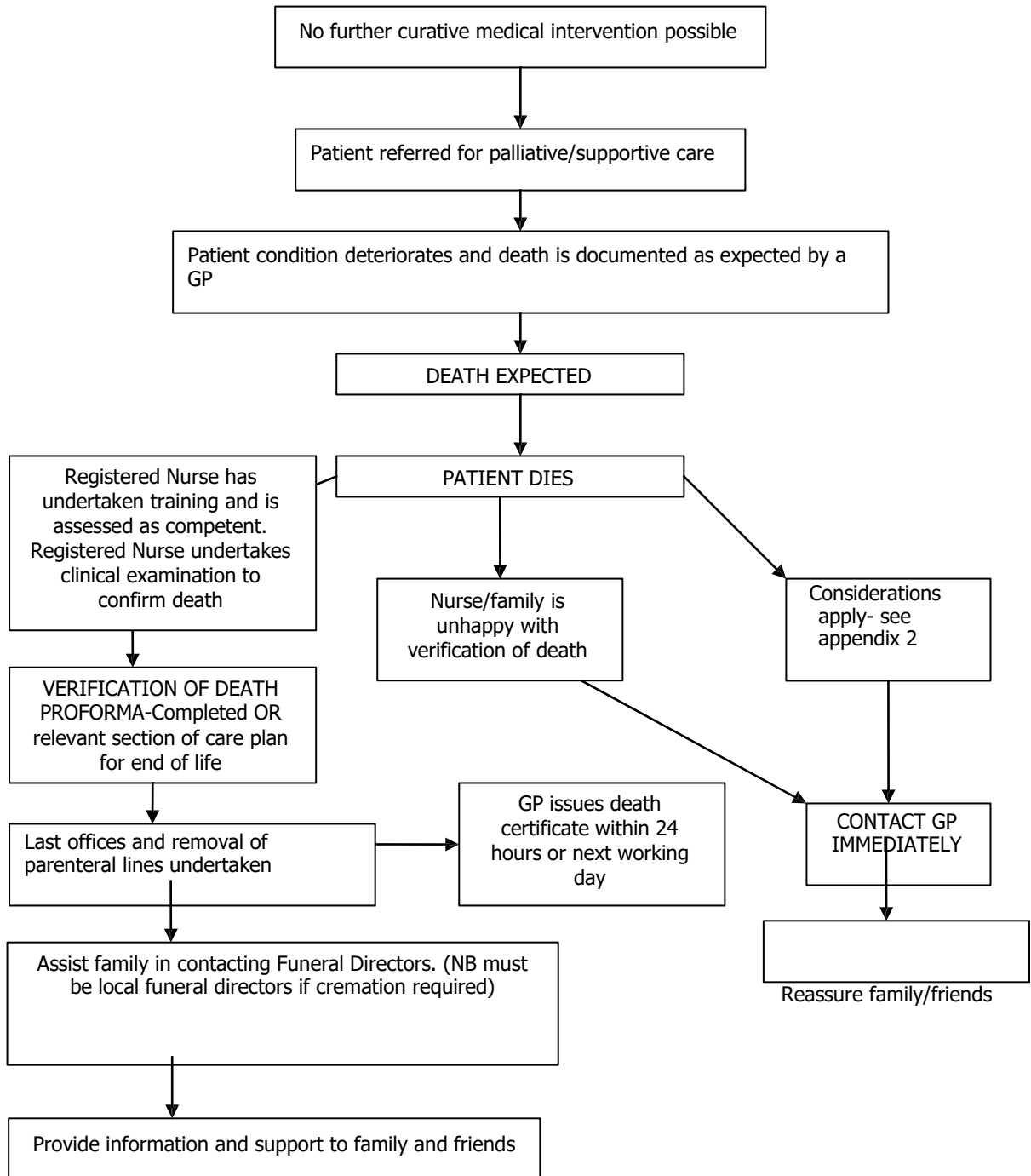
Date of Approval: 04/03/2019

Renewal Date: February 2022

**NOTE: Should the SOP be a cross divisional document then approval must be sought from all affected divisions to ensure it is a valid and sufficient document. It is the responsibility of the lead division to ensure that this is completed and evidence of such is obtained.**

**APPENDIX 1**

**NURSE VERIFICATION OF EXPECTED DEATH – FLOW DIAGRAM**



## Appendix 2

### Reportable Deaths

**Deaths are to be reported to the Coroner in the following circumstances:**

1. The cause of death is unknown
2. The death was violent, unnatural or suspicious or unexpected
3. The deceased has not been seen by the doctor within 14 days before death.
4. The death may be linked to poison or drugs
5. The death may be due in whole or part to an accident, no matter when the accident occurred
6. The death may be due to self-neglect or neglect by others, including poor care in a residential or nursing home
7. The deceased has had a surgical procedure or significant trauma (i.e. pathological fracture) in the last 12 months.
8. The death may be due to an industrial disease or related to the deceased's employment or the deceased was in receipt of industrial injury or disablement pension or war pension, even if the death does not appear to be related to the condition for which the pension has been awarded. E.g. asbestosis or mesothelioma.
9. The death may be linked to a fracture. It is best practice to report a death when the deceased has suffered a fracture within the last 12 months.
10. All children under 18 years of age
11. The death may be due to a lack of medical care or allegations of medical mismanagement have been made
12. The death may be due to the actions of the deceased, including suspected suicide, drug or solvent abuse.
13. The death occurred within 30 days of SACT (Systemic Anti-Cancer Therapy), i.e. chemotherapy or radiotherapy.

**Appendix 3**

This form needs to be completed if teams are:  
For any reason unable to comply with the policy  
You feel there is an area of the policy that needs review

DOCUMENT FEEDBACK FORM		
Title of document	Comments	Suggested solutions/changes

If you are a Community Nurse please return this form to the Care Community Service Manager. If you are a nurse working in Nursing Homes please return this form to the End Of Life Partnership.

**GP Authorisation**

Patient Name..... DOB..... NHS No.....

Address .....

In the event of this patient dying, then a qualified nurse trained in the procedure, may verify death, following the Central Cheshire Integrated Care Partnership procedure relating to verification of death by a nurse Yes/ No

**After death the undertaker can remove the body. The GP will issue a death certificate on the next working day.**

GP signature.....

Date/time .....

GP Name (please print).....

Surgery Name and Address.....

**Verification of death**

**NB: BEFORE PROCEEDING ENSURE THERE ARE NO CAUSES FOR CONCERN REGARDING THE CIRCUMSTANCES OF DEATH (follow local policy for procedures whereby concerns are raised)**

Date of death ..... Time of death .....

Persons present at time of death & relationship to the deceased.....

Notes/Comments .....

**If not present, has the individual's relative or significant other been informed?**

Name of relative informed: ..... Yes No No relative/carer

**Name of professional verifying death** ..... **Signature** .....

Role ..... Date/ Time of verifying .....

Is discussion with, or review by, the coroner required **Yes No**

The overall duration of the assessment of cardiac and respiratory function must be **at least 5 minutes**. Any spontaneous return of cardiac or respiratory activity should prompt another 5 minutes of checks.

**Vital signs checked:**

- Carotid pulse absent on palpation **Yes No**
- Heart sounds absent on auscultation **Yes No**
- Respirations absent for one minute **Yes No**

**AFTER 5 minutes of continued cardiorespiratory arrest the following checks should be made:**

- Absence of pupillary response to light and corneal reflexes **Yes No**
- No motor response to painful stimuli (trapezius muscle squeeze) **Yes No**



<b>Communication &amp; support after death</b>		<i>Signature/date</i>
<b>Care &amp; Dignity</b>	<p><b>Initial care after death is undertaken in accordance with policy</b></p> <p>Consider:</p> <ul style="list-style-type: none"> <li>• Spiritual, religious, cultural rituals/needs met</li> <li>• The facilitation of quality time with the deceased as appropriate for the care setting and to meet the needs of the family/significant others</li> <li>• Individual is treated with respect &amp; dignity if any care is provided after death</li> <li>• If CSCI/Syringe Driver in use, following verification of death, it is removed &amp; drug contents disposed of in accordance with policy.</li> </ul>	
<b>Relative/Carer/Information</b>	<p><b><i>The relative/carer understands what is required to do next &amp; given relevant written information</i></b></p> <p>Consider relative/carer information needs relating to the next steps, where appropriate</p> <ul style="list-style-type: none"> <li>• Contacting a funeral director, how a death certificate will be issued, registering the death</li> <li>• Acting on patient's wishes regarding tissue/organ donation</li> <li>• Discuss as appropriate, the need for a post mortem, or removal of cardiac devices or when discussion with the coroner required.</li> <li>• Bereavement support/services, including child bereavement services</li> <li>• Disposal of drugs &amp; equipment</li> <li>• Provision of supportive leaflet/booklets</li> <li>• Local bereavement booklet/services contacts/other bereavement information</li> <li>• DWP1027 (England &amp; Wales) 'What to do after a death' booklet or equivalent</li> </ul>	
<b>Organisation Information</b>	<p><b>The GP Practice is notified of the patient's death</b></p>	<p>Enter date/time of notification</p>
	<p><b>Other services involved notified of patient's death:</b></p>	
	<i>Out of hours services (i.e GP's, Nursing, other services)</i>	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
	<i>Hospice</i>	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
	<i>Macmillan Nurses</i>	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
	<i>Other Specialist Nurse</i>	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
	<i>Hospital</i>	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
	<i>Out Patient Services e.g Chemotherapy, endoscopy</i>	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
	<i>Community Matron</i>	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
	<i>Allied Health Professionals (i.e Physio, OT, Dietician)</i>	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
	<i>Social Services</i>	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
	<i>Continuing Health</i>	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
	<i>Other care agencies (i.e Crossroads, Marie Curie)</i>	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
	<i>Continence</i>	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
<i>Hospital Care at Home</i>	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
<i>Community equipment</i>	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
<i>Other, please state</i>		
<p><b>When this section is complete. Healthcare Professional name (print) .....</b></p> <p>Signature.....Role ..... Date/time .....</p>		