



Standard Operating Procedure

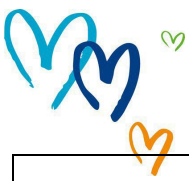
Document Type	SOP
Document Name	Verification of Expected Death by a Registered Nurse or Allied Health Professional (AHP) Working Within the Community Setting
Version	9.0
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Renewal by	May 2026
Owner	CCICP Head of Quality, Nursing and Professional Leadership
Prepared by	Head of Quality, Nursing and Professional Leadership CCICP Nurse Professional Lead
Approved by	CCICP Integrated Governance Group
Superseded documents	8.0
Relevant regulations/legislation/guidelines	NMC, BMA and Hospice UK Care after Death (fourth Edition) Hospice Uk

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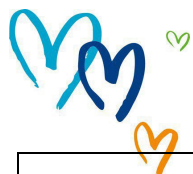
Please be advised that the Trust discourages the retention of hard copies of policies and procedures and can only guarantee that the policy on the Trust Intranet is the most up to date version

Version Control

Date	Version Number	Change Details	Approved by
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13/06/2018	4.0	<i>Updated reference material, Updated DOLS in line with regulation Removed the need for 2 yearly updates</i>	CCICP IGG
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11/10/19	5.0	<i>Inclusion of Allied Health Professionals within scope of Policy</i>	CCICP IGG
11/10/20	6.0	<i>Amended to 'Where there has been a recording within the patients EMIS record that the patient is receiving end of life care and/or the patient has a symptom Control Prescription Drugs and Administration Record for palliative care then when the patient dies the nurse/AHP will be able to verify death'</i>	CCICP IGG
06/01/21	7.0	Included the verification of death process template.	CCICP IGG
07/03/2023	8.0	Updated SOP in correspondence with latest guidance	CCICP QGG



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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 (RGN) Allied Health Professional (AHP) 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 Standard Operating Procedure (SOP) 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 SOP is for patient's dying at home or in a care home setting.

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

Verification of Death

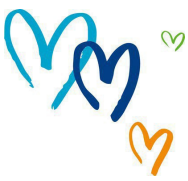
The purpose of verification of death is to determine whether a patient is actually deceased. All deaths should be subject to professional verification that life has ended.

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 or Allied Health Professional.

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 deceased must have been seen by the doctor in person or by video in the previous 28 days prior to death or in person after death. There must be no concerns regarding the care the patient has received and no requirements for the police to be called.

Where a Nurse or Allied Health Professional has any concerns that the death is suspicious then the verification of death should be passed to a General Practitioner.



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.”

The deceased must have been seen by the doctor in person or by video in the previous 28 days prior to death or in person after death.

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.

2. SCOPE

The following conditions apply.

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

The patient death has been identified as expected.

Where there has been a recording within the patient's EMIS record that the patient is receiving end of life care and/or the patient has a symptom Control Prescription Drugs and Administration Record for palliative care then when the patient dies the nurse/AHP will be able to verify death. This could be recorded on the Last Days of Life GP Template on EMIS or within the EMIS template. This will then be identifiable within the Last Days of Life Summary View record on the community EMIS system.

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/AHP may verify the death, but a GP will need to refer the death to the Coroner.

Where an expected death occurs Out of Hours and the Verification of death template on EMIS has not been completed, the Nurse will be able to undertake the verification of death as long as it has been recorded within the patient's EMIS record that the patient is receiving end of life care and/or the patient has a symptom Control Prescription Drugs and Administration Record for palliative care then when the patient dies the nurse/AHP will be able to verify death.



The policy does not apply:

In cases of sudden or unexpected death.

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

A death that has occurred as a result of an 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/AHP 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/AHP will identify the patients whose death is expected.</p> <p>GP to complete section within the Last Days of Life Template on EMIS to confirm a verification of death can be undertaken wherever possible.</p> <p>Where there has been a recording within the patients EMIS record that the patient is receiving end of life care and/or the patient has a symptom Control Prescription Drugs and Administration Record for palliative care then when the patient dies the nurse/AHP will be able to verify death.</p>	<p>1. To ensure good communication between the GP and Nurse/AHP and Out of Hours services. To provide documented evidence of discussion.</p>
<p>2. Nurse/AHP to ensure that carers/relatives have contact details for the Community Nursing Service & District Nurse Out of Hours Services.</p>	<p>2. To ensure that the carers/relatives know how to contact the nurse/AHP when the patient dies.</p>
<p>3. Nurse/AHP 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>4. 2nd Addition of Care After Death, Registered Nurse Verification of Expected Adult Deaths (RNVoEAD) Guidance.</p>
<p>5. Verification of expected death will require the Nurse/AHP to assess the patient for a minimum of 5 minutes to establish that irreversible cardi-respiratory arrest has occurred, as well as specific additional observations. Any spontaneous return of cardiac or respiratory activity during this period of observation should prompt further 5 minutes observation.</p>	
<p>a) Palpate the carotid pulse for 1 minute.</p>	<p>a) Absence of carotid pulse indicates that death has occurred.</p>
<p>b) Listen to heart sounds using a stethoscope for at least 1 full minute.</p>	<p>b) Absence of heart sounds indicates that death has occurred</p>



c) Check the absence of respiratory movement/sounds for at least one minute.	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 response to the trapezius 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 template on EMIS.	6. In line with record keeping guidance and to meet legal requirements.
7. Remove any equipment from the patient (i.e. syringe pump) Remove catheter bags and spigot any urinary catheters (if still in situ) 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 (which may be through completing the tick box on the Verification of Expected Death template on EMIS).

A record that death is expected will be documented on the EMIS system within the Last Days of Life GP Template and identifiable to the Community Nurses/AHP on the Last Days of Life summary view template.

If the relatives of a deceased patient wish to speak to a GP, this request should be requested to the GP practice/ GP out of hours.

Nursing/AHP Responsibilities

Verification of death can only be carried out by those Nurses/AHP's 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 The Code (2018). (6)

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

- Ensure there is recording within the patient records that the patient is end of life.

- 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/AHP verifying the death has the responsibility of informing the relevant Medical Practitioner. The Nurse/AHP should record the date and time this was carried out on the appropriate Verification of Expected Death template on EMIS

Where a GP has appropriately completed the Last Days of Life template on EMIS, and the patient meets the appropriate criteria, then the Out of Hours Nursing Service will be able to undertake verification of death within a nursing home setting when there is not a suitably trained nurse on duty within the nursing home setting.

Implementation

The NMC The Code 2018 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.



The HCPC standards of proficiency set out the clear expectations of registrants to work within the scope of practice by only practicing in the areas you have appropriate knowledge, skills and experience for. It also states the responsibilities of the registrants to keep their knowledge and skills up to date and relevant to their scope of practice through continued professional development.

All registered Nurses/AHP's 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.

In the event of an unexpected death or unexpected circumstances, the GP/Police 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 (second addition) – (2021), 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

2nd Edition of Care After Death, Registered Nurse Verification of Expected Adult Deaths (RNVoeAD) guidance

<http://.www.2nd-Edition-of-Care-After-Death-Registered-Nurse-Verification-of-Expected-Adult-Death-guidance>

Care After Death (fourth edition) guidance for staff responsible for care after death 2022. Hospice UK

6. Consultation and Communication with Stakeholders

The SOP was reviewed by the following stakeholders:

CCICP District Nurse Team Leaders

MCHT/ CCICP GP Out of Hours Clinical Lead & Service Manager

South & Vale Royal GP

CCICP Care Community Service Managers

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	



8.1 Internal References

- (1). Central Cheshire Integrated Care Partnership (CCICP) . Controlled Drugs Policy- Version 2 (August 2021)

[CCICP Community Services Controlled Drugs Policy.pdf](#)

8.2 External References

- (1) Births and Deaths Registration Act 1953.
- (2) Hospice UK. Care After Death (fourth edition). Guidance for staff responsible for care after death. (2022)
- (3) The Code (2018) Nursing and Midwifery Council. (NMC)
- (4) 2nd Addition of Care After Death (Fourth edition). Guidance for staff responsible for care after death (2022)

9.0 APPROVAL

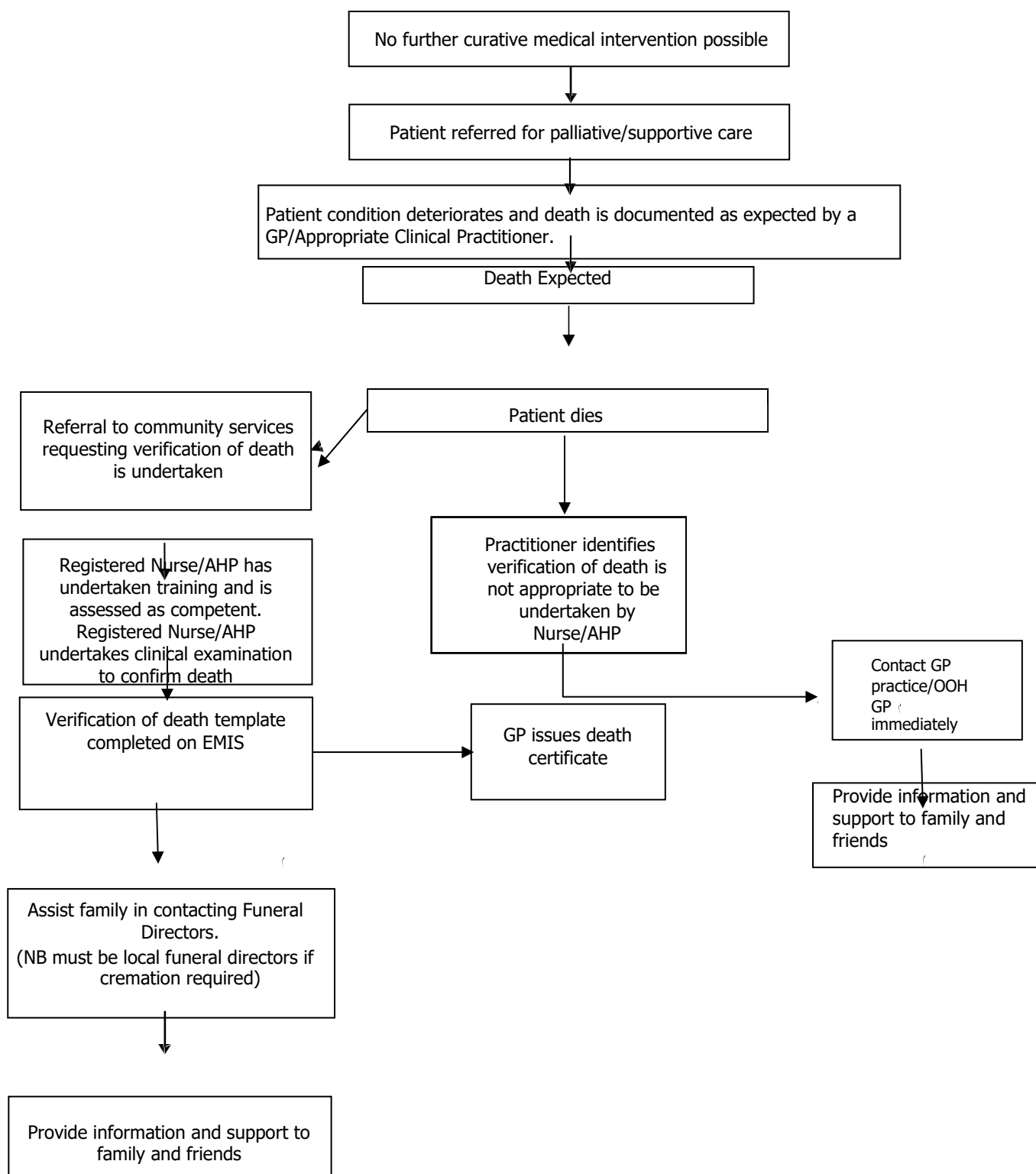
Approving Committee:	<u>CCICP Quality Governance Group</u>
Date of Approval:	<u>2nd May 2023</u>
Renewal Date:	<u>May 2026</u>

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





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.



Appendix 2

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 |
| • Respiratory Effort Absent | 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 response to painful stimuli (trapezius muscle squeeze) | Yes | No |

Communication & support after death		Signature/date
Care & Dignity	Initial care after death is undertaken in accordance with policy	
	Consider: <ul style="list-style-type: none"> Spiritual, religious, cultural rituals/needs met The facilitation of quality time with the deceased as appropriate for the care setting and to meet the needs of the family/significant others Individual is treated with respect & dignity if any care is provided after death If CSCI/Syringe Driver in use, following verification of death, it is removed & drug contents disposed of in accordance with policy. 	



Relative/Carer/Information	The relative/carer understands what is required to do next & given relevant written information		
	Consider relative/carer information needs relating to the next steps, where appropriate <ul style="list-style-type: none"> • Contacting a funeral director, how a death certificate will be issued, registering the death • Acting on patient's wishes regarding tissue/organ donation • Discuss as appropriate, the need for a postmortem, or removal of cardiac devices or when discussion with the coroner required. • Bereavement support/services, including child bereavement services • Disposal of drugs & equipment • Provision of supportive leaflet/booklets • Local bereavement booklet/services contacts/other bereavement information • DWP1027 (England & Wales) 'What to do after a death' booklet or equivalent 		
Organisation Information	The GP Practice is notified of the patient's death		Enter date/time of notification
	Other services involved notified of patient's death:		
	Out of hours services (i.e GP's, Nursing, other services)	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
	Hospice	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
	Macmillan Nurses	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
	Other Specialist Nurse	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
	Hospital	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
	Out Patient Services e.g Chemotherapy, endoscopy	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
	Complex Care Practitioners/ Advanced Community Practitioner	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
	Allied Health Professionals (i.e Physio, OT, Dietician)	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
	Social Services	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
	Continuing Health	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
	Other care agencies (i.e Crossroads, Marie Curie)	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
	Bladder and Bowel	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
	IPOCH	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	
Community equipment/Ross Care	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>		
Other, please state			
When this section is complete. Healthcare Professional name (print) Signature..... Role Date/time.....			



APPENIDX A Communication / Training needs Training needs analysis

Communication/Training Plan (for all new / reviewed documents)	
Goal/purpose of the communication/training plan	VOED training will be provided by the EoLP and following this staff will undertake competency
Target groups for the communication/training plan	All registered clinicians required to undertake VOED working within the community must undertake training and competency prior to undertaking VOED
	N/A
Methodology – how will the communication or training be carried out?	Training carried out by EoLP
Communication/training delivery	Training carried out by EoLP
Funding	CCICP commission EoLP to provide this training
Measurement of success. Learning outcomes and/or objectives	Staff feedback, successful completion of training and competency
Review effectiveness – learning outputs	Staff feedback, successful completion of training and competency
Issue date of Document	June 2023
Start and completion date of communication/training plan	N/A
Support from Learning & Development Services	N/A

For assistance in completing the Communication / Training Plan please contact the MCHT Learning and Development Services



Equality Impact Assessment

Please read the Guide to Equality Impact Assessment before completing this form.
The completed assessment is to form part of the policy/proposal/business case appendices when submitted to governance-policies@mcht.nhs.uk for consideration and approval.

POLICY/DOCUMENT/SERVICE.....

SECTION A

A	Does the document, proposal or service affect one group less or more favourably than another on the basis of:	Yes/No	Justification & data sources. Include nature of impact. Also record provisions already in place to mitigate impact.
1	Race, ethnic origins or nationality	N	
2	Sex	N	
3	Transgender	N	
4	Pregnancy or maternity	Y	GP to be requested for any pregnant ladies who have died
5	Marriage or civil partnership	N	
6	Sexual orientation including lesbian, gay and bisexual people	N	
7	Religion or belief	N	
8	Age	Y	This is for aged 18 and over, GP to undertake any under 18 VOED
9	Disability - learning disabilities, physical disability, sensory impairment and mental health problems	N	
10	Economic/social background	N	
B	Human Rights – are there any issues which may affect human rights		
1	Right to Life	N	
2	Freedom from Degrading Treatment	N	
3	Right to Privacy or Family Life	N	
4	Other Human Rights (see guidance note)	N	

Date: 2nd May 2023

Name: Joanne Bowen

Signature: *Bowen*

JobTitle: Head of Quality, Nursing & Professional Leadership



Where an impact has been identified in Section A, please outline the actions that have been agreed to reduce or eliminate risks in Section B.

If there are no impacts identified in Section A, completion of Section B is not necessary.

SECTION B

Please expand tables below as necessary

SECTION B NUMBER A1-10, B1-4	NATURE OF IMPACT	EVIDENCE	STAKEHOLDER INVOLVEMENT	ACTION	COST	LEAD	TIMESCALE	RISK SCORE

Because you  Matter