

# VERIFICATION OF EXPECTED DEATH OF ADULT PATIENTS BY REGISTERED NURSES AND ALLIED HEALTH PROFESSIONALS

*Revised with reference to Coronavirus (Emergency) Act 2020*

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## DOCUMENT CONTROL

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## 1. INTRODUCTION

- 1.1 This document provides a framework for the verification of expected death by registered nurses (RNs) and Allied Health Professionals (AHPs). A large percentage of a nurse's time is spent caring for patients who are terminally ill (Goodman 1998). Death is inevitable for all living beings (Haisfield-Wolfe 1996) and, as health care providers, nurses play a principle role in the care of dying individuals and their families. The ability of the RN/AHP to confirm the expected death of a patient and provide aftercare to relatives and carer's will provide continuity of care at a time of anxiety and distress.
- 1.2 If the RN/AHP has any concerns that the death may not be from natural causes this must be reported immediately. This will be a discussion with their line manager/doctor/GP who can discuss any issue with a coroner's officer. In the community setting out of hours the police will need to be contacted in their role as deputising for the coroner's officer.
- 1.3 If a RN/AHP does not feel suitably qualified or competent to verify an expected death, they should not undertake this and document any actions taken clearly in the patient's notes and contact a senior clinician for advice.
- 1.4 A RN/AHP must be trained and deemed competent to confirm the death, and there must be an explicit local policy in place which the nurse must check for specific details (RCN 2016).

## 2. PURPOSE & SCOPE

- 2.1 The expected outcomes of this policy are as follows:
- for the death of the patient to be dealt with in a timely, sensitive and caring manner;
  - death is dealt with in accordance with the law;
  - removal of devices prior to verification of death is illegal (The Human Rights Act 1998 articles 2 and 3 Griffith 2004);
  - registered nurses' and AHP's skills and competencies are used appropriately;
  - distress of relatives is minimised.
- 2.2 All religious and cultural needs of the patient must be taken fully into account at all times by staff and incorporated into the patient's care plan as described in the trust End of Life Care Policy.

## 3 DUTIES AND RESPONSIBILITIES

- 3.1 The **Trust Board** has overall responsibility for procedural documents and delegate's responsibility as appropriate.
- 3.2 **The Chief Nurse** will oversee implementation of this policy
- 3.3 **Matrons and service leads** are responsible for ensuring that staff are aware of the policy and that any staff training needs are identified and addressed.

3.5 **All relevant Staff** are responsible for adhering to the policy which provides a framework for best practice

#### 4. **EXPLANATIONS OF TERMS USED**

4.1 **Expected death** can be defined as death following a period of naturally occurring terminal illness where no active intervention to prolong life is occurring.

#### 5. **LEGAL POSITION**

5.1 English law at present

- **does not** require a doctor to confirm that death has occurred or that “life is extinct”
- **does not** require a doctor to view the body of a deceased person
- **does require** the doctor who attended the deceased during their last illness to issue a certificate detailing the cause of death. **COVID-19**  
*Note: See Section 5.5 for emergency legislation guidance.*

5.2 **Verification of the fact of death** is defined as deciding whether a patient is actually deceased and is required before the body can be moved

5.3 Certification of death is a process completed by a Medical Practitioner

5.4 All deaths should be subject to professional verification (*Secretary of State for Home Department, 2003*).

The Royal College of Nursing states ‘experienced registered nurses have the authority to confirm death, notify the relatives, and arrange for last offices and the removal of the body to the mortuary or the appropriate funeral parlour’ (RCN 2016).

A RN/AHP can verify the expected, natural, death of a person subject to the Mental Health Act 1983 (see Appendix D for a list of relevant sections). The team must report the death of a person subject to the Mental Health Act to the Care Quality Commission (CQC) within three days of the death. This applies to both the Community Health Directorate and the Mental Health Directorate.

A RN/AHP may also verify the expected, natural death of a person subject to an urgent or standard authorisation under the Deprivation of Liberty Safeguards.

Deaths where an industrial related disease is likely to be a cause can be verified by a RN/AHP working under the framework of this policy. An example of this would be mesothelioma. No special treatment of the body is required (in line with any infection control needs) and a person can be moved to by a funeral director or to a cold room/mortuary.

## **Coronavirus (Emergency) Act 2020**

5.5 The changes below take account of regulations in the Coronavirus (Emergency) Act 2020, and the need to restrict face to face contact and unnecessary gatherings of any sort:

Local considerations may include mobile 'verification units' to streamline processes, particularly in Out of Hours periods. As number of deaths increase, it is likely that there will be involvement of other agencies such as military and fire service in collecting bodies.

[Guidance](#) on certification of death:

- If the doctor who attended the person before death is unavailable, another doctor can sign the Medical certificate of cause of death (MCCD) for all natural deaths, including those due to Covid-19 (Although a notifiable disease, Covid-19 deaths do not need to be reported to the Coroner)
- This will only be when the certifying doctor is able to access the deceased's notes and the information supports a natural death
- There is still a requirement for the deceased to be seen after death or within 28 days prior to death by a doctor. Consultations by video (such as Skype, AccuRx) are allowable in this context, but phone consultations are not
- If a practice nurse has seen a patient during the preceding 28 days for a long-term condition review, for example, this will qualify for having been 'seen by a doctor'
- The same MCCD form will be used and amended as necessary
- There is no need for the certifying doctor to have attended the deceased during their last illness so unless there is some other reason you do not have to refer the death to the coroner.

Registration offices are currently closed, and the new regulations have extended the range of individuals able to register deaths to include funeral directors. MCCD forms are to be filled out in the normal way:

- COVID-19 is an acceptable cause of death whereas 'unascertained' is not
- Certificates should be sent electronically to the secure local authority instead of giving it to the informant. Hardcopies should have the information "MCCD, Surname, Forename, Date of Death" on each page in case they should become separated. These can be sent to be processed in the normal way when the 'emergency period' is over.
- Relatives should be asked to ring 01823 282251 to make an appointment to complete the registration process over the phone with a registrar

## 6 TRAINING REQUIREMENTS

- 6.1 A RN/AHP may only undertake verification of expected death if they have attended face to face training or completed eLearning on Verification of Expected Death, and either passed the eLearning or been assessed as competent (See appendix E). eLearning is available on the Learning Zone and on Mollie.

## 7 IMPLANTABLE CARDIOVERTER DEFIBRILLATORS

- 7.1 While an ICD is active, the patient's family should be reminded that if the device does discharge, it is by means of a low energy internal shock which is harmless to anyone in physical contact with the patient. It is safe to touch a body and verify death even if the ICD defibrillation function has not been deactivated.

## 8 VERIFICATION OF EXPECTED DEATH

### 8.1 Patients to whom this policy refers:

- **expected natural death** can be defined as death following a period of terminal illness where no active intervention to prolong life has occurred
- this policy only pertains to patients when a 'Do not attempt CPR' decision has been made and documented on a TEP form or similar valid document.
- **the RN/AHP is also able to evidence the 'expected' nature of the death using the 'Expected Death Supporting Evidence Tool' In appendix A.**

### 8.2 Medical responsibilities

- It is good practice for doctors to see patients regularly to monitor symptom control and provide support and information when they are dying
- A doctor/GP does not need to have seen a patient in the 2 weeks prior to their death to verify death has occurred.
- Certification of cause of death must be done by a doctor in accordance with current [national guidance](#).

*COVID-19 Note: See Section 5.5 for emergency legislation guidance.*

### 8.3 RN/AHP responsibilities

- Ensure an 'Do not attempt CPR' decision is in place and documented
- Complete the 'Expected Death Supporting Evidence Tool' and verify the death.
- Complete the 'Verification of the Fact of Death Form'.

8.4 The fact of death should be communicated to the doctor responsible for the patients' care as soon as possible following death. In the community setting, in hours this may be the patients' own GP or out-of-hours this may be the GP out-of-hours service. (see Appendix C).

8.5 A medical certificate for the cause of death will be completed by a doctor involved in the patient's care at the earliest available opportunity

*COVID-19 Note: See Section 5.5 for emergency legislation guidance.*

8.6 Parenteral drug administration equipment (for example as syringe driver) can be stopped prior to the process of a verification examination but can only be removed once verification of death has been completed.

## **9 EXCEPTIONS TO VERIFYING DEATH**

9.1 There will be exceptions where a RN/AHP cannot verify death and the doctor should be called. It is the doctor's responsibility to refer the death to the Coroner:

- if the patient is under 18 years of age;
- if there is any evidence of suspicious circumstance;
- all sudden and unexpected deaths (including no supportive information indicating an expected death);
- if there is evidence of neglect, negligence or malpractice;
- after any operative or invasive procedure which may have contributed to the death;
- deaths following an untoward incident or drug error;
- after a fall which may have contributed to the death;
- if there is any evidence of suicide;
- If there is evidence of recent self-harm;
- if there is any evidence of an accident;
- where organ/tissue donation has been requested and urgent medical intervention is needed to remove the appropriate organ/tissue or make the appropriate arrangements. This also includes circumstances where the patient has consented to their body being donated to medical sciences;
- where relatives specifically request to see the Doctor/ GP;
- when the RN/AHP has a good reason for needing the support of a Doctor/GP;
- when the Doctor/ GP feels he/ she should be present.

9.2 If anything untoward or unlawful is suspected please contact the manager (on call manager out of hours) who will discuss if the police need to be involved. If they do, please preserve the scene and later complete an incident form.

9.3 In the community setting, in instances of doubt regarding evidence at the home, the RN/AHP should contact a senior colleague/manager for advice. They would then be able to review contemporaneous records for evidence that may not be present in the home and support the decision maker.



## 10. EQUALITY IMPACT ASSESSMENT

- 10.1 All relevant persons are required to comply with this document and must demonstrate sensitivity and competence in relation to the nine protected characteristics as defined by the Equality Act 2010. In addition, the Trust has identified Learning Disabilities as an additional tenth protected characteristic. If you, or any other groups, believe you are disadvantaged by anything contained in this document please contact the Equality and Diversity Lead who will then actively respond to the enquiry.

## 11. MONITORING COMPLIANCE AND EFFECTIVENESS

- 11.1 An audit of documentation will be completed according to the Trust's record keeping policy. Audit standards have been developed. (Appendix F).
- 11.2 All incidents, feedback and complaints related to verification of expected death will be reviewed by the End of Life Best Practice group. Any good practice and/or learning points will be fed back to the relevant Best Practice Groups. Clinical supervision sessions will be offered to staff involved in any VEOD incidents.

## 12. RELEVANT CARE QUALITY COMMISSION (CQC) REGISTRATION STANDARDS

- 12.1 Under the **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)**, the fundamental standards which inform this procedural document, are set out in the following regulations:

Regulation 9:	Person-centred care
Regulation 10:	Dignity and respect
Regulation 11:	Need for consent
Regulation 12:	Safe care and treatment
Regulation 13:	Safeguarding service users from abuse and improper treatment
Regulation 15:	Premises and equipment
Regulation 16:	Receiving and acting on complaints
Regulation 17:	Good governance
Regulation 18:	Staffing
Regulation 19:	Fit and proper persons employed
Regulation 20:	Duty of candour
Regulation 20A:	Requirement as to display of performance assessments.

- 12.2 Under the **CQC (Registration) Regulations 2009 (Part 4)** the requirements which inform this procedural document are set out in the following regulations:

Regulation 16:	Notification of death of service user
Regulation 18:	Notification of other incidents

- 12.3 Detailed guidance on meeting the requirements can be found at <http://www.cqc.org.uk/sites/default/files/20150311%20Guidance%20for%20providers%20on%20meeting%20the%20regulations%20FINAL%20FOR%20PUBLISHING.pdf>

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## 13.2 Cross reference to other procedural documents

- Equality and Diversity Policy
- Learning Development and Mandatory Training Policy
- Record Keeping and Records Management Policy
- Risk Management Policy and Procedure
- Serious Incidents Requiring Investigations (SIRI) Policy
- Untoward Event Reporting Policy and procedure

All current policies and procedures are accessible in the policy section of the public website (on the home page, click on 'Policies and Procedures'). Trust Guidance is accessible to staff on the Trust Intranet.

## 14. APPENDICES

14.1 For the avoidance of any doubt the appendices in this policy are to constitute part of the body of this policy and shall be treated as such.

Appendix A	Expected Death Supporting Evidence Tool
Appendix B	Verification of the Fact of Death Form
Appendix C	Verification of Expected Death by a RN/AHP (Flowchart)
Appendix D	Procedure if a Patient is Detained Under the Mental Health Act 1983
Appendix E	Competencies for Verification of Expected Death in Adults
Appendix F	Clinical Audit Standards

### Expected Death Supporting Evidence Tool

<b>Patient's Name</b>	
<b>NHS Number</b>	
<b>Date of Birth</b>	
<b>GP</b>	

**Resuscitation Category (Please document)** If not valid, consider basic life support and obtaining assistance.

**If Treatment Escalation Plan or equivalent is available and states 'Do not attempt CPR' – continue, if not - look for supporting evidence as below:**

**Supportive information that this is an expected death: such as, but not limited to (tick if present):**

End-of-life care plan and communication tool	Palliative care paperwork	Evidence of decline towards natural death
Anticipatory prescribing	Documentation of EOL	EPACCS information
CHC Fast track funding	DS1500 completed	Other; please state

**Are you satisfied that this death is expected?**

<b>Yes: Proceed to verify death</b>	No: Call manager
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**Are the people present at the time of death satisfied there are no untoward circumstances?**

<b>Yes: Proceed to verify death</b>	No: Call manager
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**Are there any obvious extenuating circumstances in the patient environment which would preclude you from verifying death?** E.g. recent fall, obvious unexplained injury, drug error, any exclusion listed in VoD policy.

<b>No: Proceed to verify death</b>	Yes: Call manager
------------------------------------	-------------------

<b>Name:</b>	<b>Signature:</b>	<b>Date:</b>	<b>Time:</b>

### VERIFICATION OF THE FACT OF DEATH

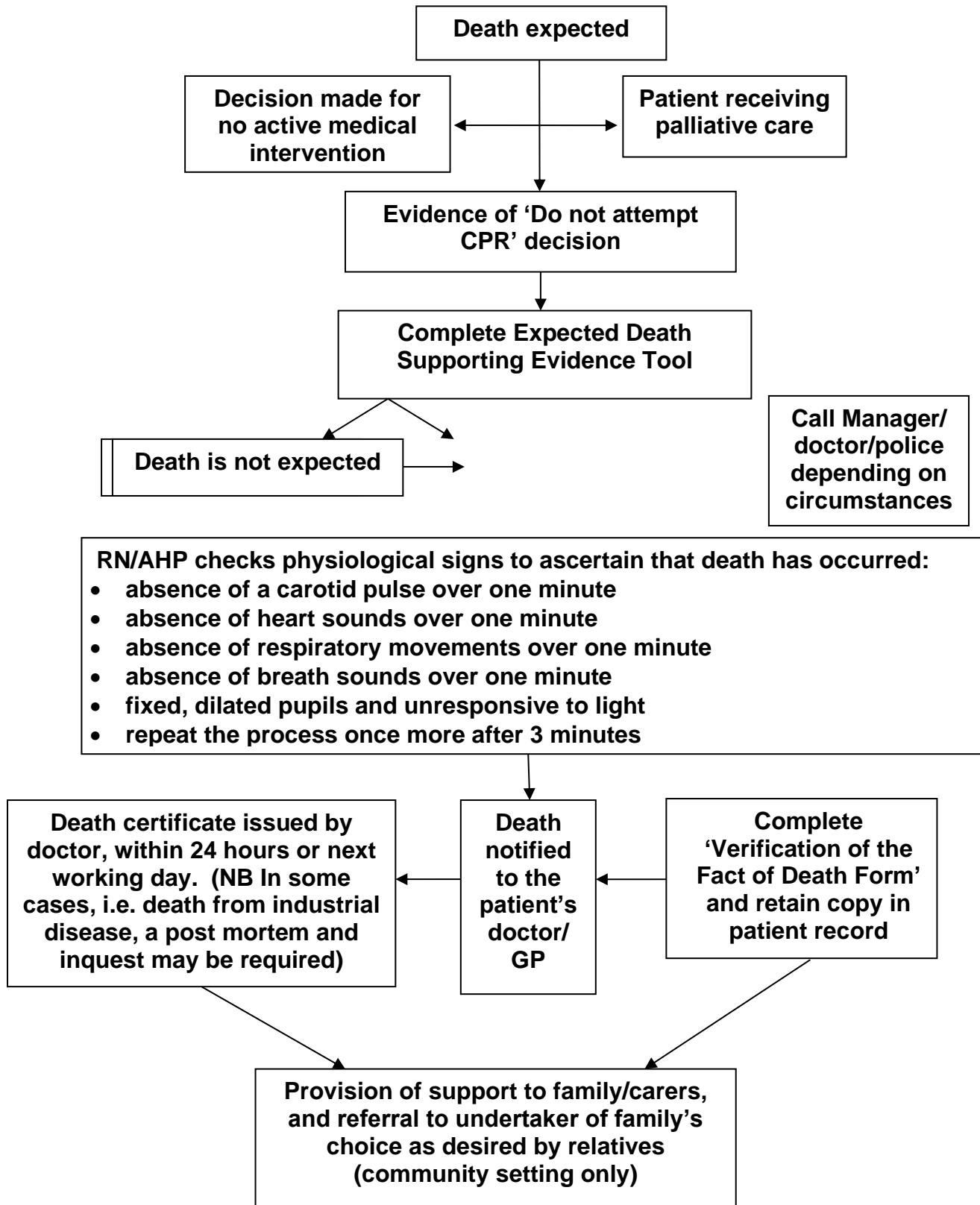
<b>Are you satisfied the patient can be verified according to the Expected Death Supporting Evidence Tool?</b>	Yes: proceed	No: Call manager
Place, date and time of suspected death:	Death witnessed/ found by (include contact number):	
Patient's name:		
Date of birth:		
Patient's address:		
Usual registered GPs name:	Date and time contacted:	

<b>Please complete the following:</b>	Heart sounds and carotid pulse absent over one minute	Respiratory movements and breath sounds absent over one minute	Pupils fixed and dilated (and do not react to light)
Date:			
Time:			
Signature:			

<b>Repeat after three minutes</b>	Heart sounds and carotid pulse absent over one minute	Respiratory movements and breath sounds absent over one minute	Pupils fixed and dilated (and do not react to light)
Verified date of death:			
Verified time of death:			
Signature:			

Medical Practitioner notified:	Yes / No	at	am / pm
Relatives/neighbour contacted:	Yes / No	at	am / pm
Minister of religion contacted if required:	Yes / No	at	am / pm
Necessary advice and documentation given to relatives and carer:	Yes / No	at	am / pm
Other services involved in care informed (ASC, Hospice, Marie Curie, OOH teams):	Yes / No	at	am / pm
CQC informed if patient is detained under the Mental Health Act in an inpatient unit:	Yes / No /NA	at	am / pm
<b>Death verified by: (please print)</b>	<b>Signature:</b>		<b>Qualification: (e.g. RN)</b>

**FLOWCHART FOR VERIFICATION OF EXPECTED DEATH**



(Adapted from West Lincolnshire Primary Care Trust)

**Procedure for completing and submitting the CQC form: ‘Statutory notification about the death of a person detained or liable to be detained by the registered person under the Mental Health Act 1983’.**

This form must be completed whenever any patient subject to powers within The Mental Health Act dies, no matter what the circumstances of the death.

This includes patients subject to Sections within Part II of the Act (2, 3, 4, 5, 7, 17, 17A, 135, 136) and patients subject to Sections within Part III of the Act (35, 36, 37 (with or without S41 restrictions), 38, 44, 47, 48).

The form is periodically amended by CQC and can be accessed via:  
[www.cqc.org.uk/mhanotifications](http://www.cqc.org.uk/mhanotifications)

### **Procedure**

1. Nurse in charge of the ward (or care coordinator for CTO patients) completes electronic CQC form and an incident form
2. Nurse or care coordinator e-mails completed form to the Mental Health Act administrators
3. Administrator e-mails it to MHA coordination manager and Legal Strategies manager
4. Managers check form for accuracy and liaise with the person who completed the form if there are any gaps, or if anything requires further explanation
5. Managers return form to administrators and copy in corporate governance manager
6. Administrator e-mails form to CQC using a secure NHS.NET account.



## **COMPETENCIES FOR VERIFICATION OF EXPECTED DEATH IN ADULTS**

### **(To be completed following face to face training)**

Nursing and Midwifery Council (NMC); (2018); The Code Professional standards of practice and behaviour for nurses and midwives

Royal College of Nursing (RCN) 2016: Confirmation or verification of death by registered nurses

West Lincolnshire Primary Care Trust. Verification of Death by Registered Nurses

Somerset Partnership related documents:

- Assessing Competence in Clinical Practice Protocol.
- Verification of Expected Death of Adult Patients by Registered Nurses
- Equality and Diversity Policy
- Learning Development and Mandatory Training Policy
- Record Keeping and Records Management Policy
- Risk Management Policy and Procedure
- Serious Incidents Requiring Investigations (SIRI) Policy
- Untoward Event Reporting Policy and procedure

The purpose of these competencies is to clarify the knowledge and skills expected of practitioners to ensure safe practice in verifying expected death in adult patients.

Once the practitioner has reached a satisfactory level of competence following a period of supervised practice, ensure they are formally competency assessed by an appropriate practitioner.

The self-rating scale is to be used by the individual practitioner for self assessment of present performance during supervised practice, and to help identify learning needs. Their line manager, or other experienced practitioner, must then assess these skills and sign to confirm competency.

Only Doctors or registered practitioners with an NMC/AHP recognised teaching and assessing in practice qualification and have undergone training and competency assessment in verifying expected death in adults, can be identified as assessors.

#### Key for Self-Assessment

1 = No knowledge/experience

2 = Some knowledge/experience

3 = Competent

4 = Competent with some experience

5 = Competent, experienced and able to assess others

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Date: November 2013

Updated: September 2016 (Reviewed April 2020)

Review:

Assessment of competency for Verification of Expected Death

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I confirm that I have self-assessed as competent to practice Verification of death of adult patients:

Practitioner's Name: .....

Practitioner's Qualification: .....

Practitioner's Signature: ..... Date: .....

**I confirm that I have assessed the practitioner named above as competent to verify expected death in adult patients.**

Name and Title: .....

Signature: ..... Date: .....

**Upon successful completion of your assessment of competency please send to your line manager and retain a copy for yourself.**

Knowledge and Skills for Verification of Death		Self Assessment			Formal Assessment	
		Score	Tick	Date and Comments	Signature	Date and Comments
1	Describe the difference between certification and verification of death	1				
		2				
		3				
		4				
		5				
2	Discuss when a registered nurse/AHP can verify death and what documentation needs to be in place	1				
		2				
		3				
		4				
		5				
3	What are the circumstances that death may need to be reported to the coroner	1				
		2				
		3				
		4				
		5				
4	Discuss the legal requirements regarding removal of medical devices	1				
		2				
		3				
		4				
		5				
5	Discuss who should be informed that a patient has deceased	1				
		2				
		3				
		4				
		5				
6	Assessment in the clinical procedure for verifying cessation of cerebral function, respiration and circulation in accordance with local policy.	1				
		2				
		3				
		4				
		5				