Hospice at Home
Carlisle and North Lakeland

VERIFICATION OF EXPECTED DEATH POLICY

Document Summary

This policy is to enable Registered Nurses working for Hospice at Home Carlisle and North Lakeland to verify the expected deaths of Adults.

This is the final version of this document and all other versions must be destroyed.

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Policy Author	Senior Staff Nurse
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1. SCOPE

This policy applies to Registered Nurses working for Hospice at Home Carlisle and North Lakeland (Hospice at Home) working within a community setting.

2. INTRODUCTION

Death must be verified by a suitably qualified person.

There may be lengthy delays before a GP is able to visit a patient to verify that death has occurred; this may be a source of distress to family and carers.

Out of hours, some relatives and carers may prefer to have death verified by a member of the Hospice at Home team who is known to them rather than an unfamiliar Out of Hours GP (OOH GP).

When undertaking verification of expected death, Registered Nurses may improve the experience of relatives and carers by reducing delays and through relationships already established.

Many Registered Nurses want to perform this extended scope activity for personal and professional reasons.

Funeral Directors require a health professional to verify that death has occurred before removing the deceased person.

Following a verification of expected death by a Registered Nurse, it is still necessary for a doctor to complete a medical certificate of the cause of death.

3. STATEMENT OF INTENT

This policy is to enable Registered Nurses working for Hospice at Home to verify the expected death of a patient aged 18 and above.

4. DEFINITIONS

Expected death – an expected death is when the expected and inevitable outcome is death. It is not an expected death if any of the exclusion criteria (6.3) apply.

A death can be expected in the following situations:

- The patient has a known terminal condition. The patient, family and carers are aware that the condition is terminal and primary health care and/or palliative care teams are involved.

- An elderly patient, who has had a period of deterioration and increasing frailty. They will have been assessed by their GP within the preceding 2 weeks and felt that the inevitable outcome is death due to old age.

5. DUTIES

5.1 Registered Nurses

It is the responsibility of the individual Registered Nurse to ensure that they have received training and been assessed as competent before undertaking verification of expected death. It is also the Registered Nurses' responsibility to collect evidence of maintenance of competency. This will be done through reflective learning and case discussion at clinical supervision.

5.2 Line Manager

The Line Manager is responsible for identifying Registered Nurses who should undertake this role, releasing these nurses for training and ensuring there is a record of competence in the individual Registered Nurses' personal file.

The Line Manager is responsible for discussing verification of death in clinical supervision sessions.

6. VERIFICATION OF EXPECTED DEATH

6.1 Procedure

During GP surgery opening times, GP's will remain responsible for certification of death. This is unless an alternative arrangement has been agreed between the GP and Registered Nurse, on an individual case basis.

In the OOH period all deaths will be logged with the OOH provider i.e. CHOC, to be triaged by a doctor. If the death is not excluded by the exclusion criteria (6.3) and there is added value of nurse verification over doctor certification, the nurse can continue with verification of death.

The verification of death is undertaken at the Registered Nurse's discretion, after discussion with the on-call doctor, if they have had the appropriate training and been assessed as competent. ***Appendix 2 and 3***

If the Registered Nurse is present at the time of death they may verify death if appropriate and log the case with the OOH provider.

Verification can only be undertaken when death is the expected and inevitable outcome.
The GP and others from the Primary Health Care Team will have been attending the patient to provide medical and nursing support prior to death.
The relatives of the patient should have been aware that death was expected.

Death will be verified using the following criteria;

- Absence of carotid pulses over 1 minute
- Absence of heart sounds over 1 minute
- Absence of respiratory movements and breath sounds over 1 minute
- Pupils not reacting to light
- No response to painful stimuli

The verification examination will be repeated after 5 minutes or prior to last offices (see clinical examination procedure 6.2).

Auscultation skills of normal health and breath sounds will be included in the training session.

Where the nurse is in any doubt she/he should liaise with the doctor.

Where appropriate the Registered Nurse should notify the next of kin that the patient has died and the death has been verified. This may involve contacting them by telephone, unless it is specified that relatives do not wish to be contacted, for example through the night if the next of kin is not present.

Parenteral drug administration may be discontinued after verification of death.

The verifying nurse will complete the form for Verification of Expected Death **(*Appendix 1)*** and file it in the patient's notes. If the patient is on an End of Life Care plan, this form must also be completed (if available), as the verification form in the plan is not comprehensive enough.

The OOH provider will notify the patient's GP and code the case of death administration to aid data collection.

6.2 Clinical Examination

It is essential that the nurse takes time to observe the patient for any spontaneous movement or any reaction to the environment e.g. chest movement, swallowing, coughing, nasal flaring and eye movement, whilst in the process of verifying death.

The nurse should ascertain any air entry into the lungs by applying the chest piece of a stethoscope to the patient's chest area with a firm even pressure and held still, to prevent friction sounds which can mimic breath sounds. Sounds are modified and louder in the trachea and main bronchi area, especially at the apices of the lungs.

The nurse should assess the cessation of circulation when the following signs are noted;

- Unconsciousness
- Apnoea

- Death like appearance (cyanosis or pallor)
- Absence of the pulse in the large arteries (e.g. carotid artery)

Absence of the carotid artery pulse is the most important sign and should be favoured over absence of heart sounds. Peripheral pulses may be absent in spite of the presence of the carotid pulse, particularly in hypovolaemia. Palpation of the femoral artery is an alternative way of checking for the presence or absence of pulses.

The nurse should be accustomed to using a stethoscope and be experienced in listening to healthy heart sounds before assessing the absence of heart sounds.

In the healthy adult, the apex beat lies in the 5th intercostal space, within the mid clavicular line. Various conditions may result in an abnormal position of the apex.

If heart sounds are not heard at the apex, the pulmonary and aortic areas may also be auscultated. The pulmonary area is usually best heard at the second or third intercostal spaces to the right of the sternum.

The nurse must also check the patient's pupil reaction. A very bright light is required and it may be necessary to darken the room. The nurse should direct the light from the side of the patient to avoid an accommodation response. The reaction or absence of reaction of the pupils to the light should be assessed in each eye separately, shielding the other eye from the light whilst doing so. In death both pupils should be fixed and unresponsive to bright light.

The verification examination will be repeated after 5 minutes or prior to last offices.

6.3 Exclusion Criteria

Nurses must not verify any deaths in the following categories as a post mortem or routine referral to the coroner's office may be indicated;

- An unexpected death
- A child
- An unidentified person
- Anyone who has not been seen by their GP or attending doctor in the previous 14 days
- A death within 24 hours of onset of illness or where no firm clinical diagnosis has been made
- A death occurring less than 1 year after an operation or other invasive procedure
- A death following an untoward incident, fall or drug error
- A death occurring as a result of negligence or malpractice
- A death due to mesothelioma or any industrial related disease

- Any unclear or remotely suspicious death

In these cases the GP or OHH doctor must refer the death to the coroner.

7. TRAINING

Training required to fulfil this policy will be provided.

8. MONITORING COMPLIANCE WITH THIS POLICY

The table below outlines Hospice at Home Carlisle and North Lakeland's monitoring arrangements for this policy.

Aspect of compliance or effectiveness being monitored	Monitoring method	Individual responsible for the monitoring	Frequency of the monitoring activity	Committee which will receive the findings /monitoring report
Registered Nurses are undertaking appropriate verification of expected deaths.	Audit of 10% sample of cases of nurse verification. Cases will be identified from patient notes	Senior Staff Nurse	Annually	Assurance Committee
Adequate education and training is being provided, appropriate for the number of cases of verification being performed	Analysis of date	Senior Staff Nurse		

9. REFERENCES /BIBLIOGRAPHY

This policy has been developed from the previous policy procedure for Verification of Expected Death by Cumbria PCT / Cumbria Partnership NHS Foundation Trust.

British Medical Association (1999) Confirmation and certification of death Guidance for GPs in England and Wales, London, BMA
Nursing and Midwifery Council (2004). The NMC Code of Professional Conduct; standards for conduct, performance and ethics.
Royal College of Nursing (1996) Verification of Death by Registered Nurses, RCN, London
UKCC (2000) Perceptions of the Scope of Professional Practice for Nurses

10. RELATED POLICY/PROCEDURES

None

APPENDIX 1

APPENDIX 1 – RECORD OF VERIFICATION OF EXPECTED DEATH BY NURSING STAFF

Identification of Patient
Name:
…….....
D.O.B.:…….
.....
Hospital Number/NHS
Number:……..

	The Patient died at	Time	Date
	Persons present at death		
	Patient has died in the absence of a doctor	Yes	No
	GP and relatives aware of expected death	Yes	No

Exclusion criteria:

- An unexpected death
- A child
- An unidentified person
- Anyone who has not been seen by their GP or attending doctor in the previous 14 days
- A death within 24 hours of onset of illness or where no firm clinical diagnosis has been made
- A death occurring less than 1 year after an operation or other invasive procedure
- A death following an untoward incident, fall or drug error
- A death occurring as a result of negligence or malpractice
- A death due to mesothelioma or any industrial related disease
- Any unclear or remotely suspicious death

If any of these criteria apply, please discuss the case with a GP

Clinical Signs

		Initial	5 mins
	Lack of spontaneous activity		
	Absence of respiration		

	Absence of carotid and brachial sounds		
	No response to painful stimuli		
	Pupils not responding to light		
	Relatives informed		
	OOH provider i.e. CHOC informed		
	Signature of nurse verifying Death		
	Print name of nurse verifying death		

Please retain in patient's medical/nursing notes

APPENDIX 2

EDUCATION OUTLINE FOR WORKSHOP ON VERIFICATION OF EXPECTED DEATH POLICY

Name of Workshop:
Verification of Expected Death in the Community

Aim of Study Day:
To introduce and prepare participants to implement the verification of expected death policy in their clinical practice.

Learning Outcomes:
At the end of the day participants should be able to;

- Define what is meant by 'expected death'
- Demonstrate an understanding of the policy and why it is needed
- Identify and recognise the clinical signs of death and conduct a clinical examination of the 3 systems – eyes, heart, respiratory – and verify death as per policy. Auscultation of normal heart and breath sounds will be included.
- Demonstrate the knowledge to provide bereaved family with supporting and appropriate information so that they know what to do next
- Demonstrate the ability to record the fact of death correctly (*Appendix 1*)
- To have increased understanding of the legal and professional framework in relation to the verification of expected death
- To have an increased understanding of the role of the Coroner and the related legal issues and identify the situations and circumstances when nurses should not verify death

Who is it for?
Registered Nurses working for Hospice at Home who wish to extend their scope of practice to verify death. Assessment of competence is mandatory before a Registered Nurse can verify expected deaths in the community.

Programme Information
One 2 hour workshop
Certificate of attendance will be given

APPENDIX 3 – ASSESSMENT OF COMPETENCE REGISTERED NURSE VERIFICATION OF EXPECTED ADULT DEATH

Name of RGN…….

Base…….

Competency	**Satisfactory**	**Unsatisfactory**
The registered nurse demonstrates a clear understanding of their own responsibilities and accountabilities		
The registered nurse demonstrates a clear understanding of the CPFT Verification of Expected Death Policy		
The registered nurse is able to recognise potential clinical signs of death		
The registered nurse can indicate anatomical landmarks to identify absence of; 1. Signs of respiration 2. Signs of circulation 3. Heart sounds		
The registered nurse is aware of anatomical regions suitable to administer painful stimuli		
The registered nurse to demonstrate the ability to examine the response of the pupil to light		
The registered nurse to demonstrate completion of appropriate documentation		

I certify that the above named Registered Nurse has demonstrated a satisfactory level of verification of Expected Adult Death with patients.

Assessor's signature ……

Date …….