Verification of Expected Death Policy (Adults)
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1. INTRODUCTION

Verification of Expected Death is the procedure of determining whether a patient is actually deceased (RCN, 2016). A Registered Nurse (RN) can verify that an expected death has occurred if there is a local policy to support the RN. It is important to note that the law dictates that a Medical Certificate of Cause of Death (MCCD) is written by a registered medical practitioner in accordance with the Births and Deaths Registration Act 1953 (Wilson, Laverty and Cooper, 2016, BMA, 2016).

Verification of expected death by a competently trained RN allows for timely provision of appropriate care for the deceased and their family, thus minimising distress caused by unnecessary delays at such an emotional and vulnerable time.

Following the verification process the RN can instruct the timely removal of the deceased to the appropriate onward location e.g. Funeral Directors.

In addition, if a situation is identified during the verification procedure that requires a referral to the Coroner (section 5.2), the RN can explain the rationale and offer on-going support.

It is important to advise the family that there may be a delay between time of last breath (often reported by the family/carer) and time of verification of death, which is the official time of death. It is this time that should be documented in the patients records. Please note: if a patient takes their last breath before midnight and verification takes place after midnight, the official date of death remains as the date and time of verification.

Wilson, Laverty and Cooper (2016) define an expected and unexpected death as:

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. Please note: for nurse verification a doctor must have seen the patient in the last 14 days’.

A Sudden or Unexpected Death:
An 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 circumstances can be justified).

2. PURPOSE

The purpose of this policy is to provide guidance and set out the organisational arrangements for implementing best practice in relation to the Verification of Expected Death procedure for both community and the Hospice.
To provide legislative guidance for situations requiring a referral to the Coroner and local arrangements for referrals to the Coroner within the Borough of Doncaster.

To provide guidance for nursing and medical staff supporting patients whose death in the near future is inevitable, enabling them to explain to patient/relatives/carers the procedures that take place following an expected death and the services that may be involved.

3. SCOPE

This policy applies to:

- All RDASH employed Registered Nurses who are appropriately trained, and assessed as competent, to undertake the Verification of Expected Death procedure in the community and Hospice services.
- All General Practitioners (GP’s) and doctors working in RDASH who request an RDASH employed RN to undertake the Verification of Expected Death procedure during Out of Hours (community only) and all hours within the Hospice.

Other RDASH inpatient settings are not included in this policy as they do not care regularly for patients at the end of life, therefore nurses working in those areas would not be required to verify expected death.

This policy will support the referring GP and/or doctor in their decision making when deciding when it is and is not appropriate to request a RN to verify that an expected death has occurred.

4. RESPONSIBILITIES, ACCOUNTABILITIES AND DUTIES

4.1 Chief Executive

The Chief Executive is responsible for making arrangements to support the safe and effective implementation, monitoring and review of this policy.

4.2 Medical Director

The Medical Director is responsible for the implementation and monitoring of the policy.

4.3 Medical Staff

Consultants and Medical Staff are responsible for the safe and effective implementation and monitoring of this policy.

4.4 Area Clinical Managers/Modern Matrons/Team Leader/Ward Managers

The Area Clinical Managers/Modern Matrons/Team Leaders/Ward Managers are responsible for the safe and effective implementation of this policy.
In addition:

- Monitoring compliance relating to RN training and competency outlined in this policy.
- Ensure suitable trained RN’s are available within their areas to undertake the verification of death procedure.
- Monitor inappropriate referrals and actions taken.

4.5 Registered Nurses

All RN’s who have undertaken the required training, who are assessed as competent (appendix 1 and 2) and have been assessed using RDASH Clinical Skills Assessment Tool (appendix 3) to verify that an expected death has occurred are responsible for:

- Ensuring their knowledge and skills are kept up to date
- Ensuring they follow the verification of death procedures.
- Ensuring documentation is accurate and up to date.
- Ensuring referral to coroner office is requested in line with legislative guidance
- Ensuring escalation to senior staff if issues arise.

5. PROCEDURE/IMPLEMENTATION

5.1 Guidance

The following guidance is based on best evidence and legislative guidance available. Throughout this guidance coroner referral processes relate to referrals for the Coroner within the Borough of Doncaster only.

Coroner processes may be different outside the Borough of Doncaster, therefore for patients who live in the community but reside outside the Borough of Doncaster, even if they are registered with a Doncaster GP, will be the responsibility of the requesting GP/doctor for Out of Hours Services. RDASH employed RNs are unable to verify expected deaths regarded as out of area.

5.2 Situations that Require a Referral to the Coroner

- Every situation where the doctor treating the patient is unable to provide a Medical Certificate of The Cause of Death. (MCCD).
- Where the death may be due to suicide
- Where the death occurred during or shortly after detention in police or prison custody
- When death occurs within 24 hours of admission to an Inpatient Unit.
- Where the cause of death is unknown/unexpected.
- Where the deceased had not been seen by the medical practitioner within 14 days of the death (the ‘14 day rule’) for the condition from which the patient has died or where the certifying doctor did not see the deceased after death.
- Where the cause of death may have been unnatural, violent or attended by suspicious circumstances.
- Where the death may have been due to self-neglect or neglect by others.
- Where death may be due to industrial disease or industrial poisoning or related to their employment history.
- Where death is due to an abortion.
- Where the death occurred during surgery or before full recovery from the effects of an anaesthetic that may contribute to the death.
- Where there is any evidence of concern following examination of the body.
- Where relatives express any concerns relating to professional management if related to the cause of death. (Births and Deaths Registration Act 1953)

If a patient has an industrial disease and was expected to die an RN may verify death, however the RN must complete letter 2 (appendix 4) and follow guidance in section 5.3.

It is important to note that a GP from the Out of Hours Services cannot legally give a medical certificate showing the cause of death if they have not attended the deceased in the last 14 days for the condition which is known to be the cause of their death. (BMA, 2016)

This section also applies to patients who, at the end of their life, have been discharged home from the acute trust or hospice services but have not been seen by their own GP within the last 14 days for the condition which is known to be the cause of their death.

If a patient has a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in place this does not automatically mean that the death is expected. Therefore, if a contraindication is identified, a referral to the coroner will be required.

Deprivation of Liberty Safeguards:

From Monday 3 April 2017 coroners no longer have a duty to undertake an inquest into the death of every person who was subject to an authorisation under the Deprivation of Liberty Safeguards (known as DoLS) under the Mental Capacity Act 2005.

Any person subject to a DoLS authorisation who dies, their death need not be reported to the coroner unless the cause of death is unknown or where there are concerns that the cause of death was unnatural or violent, including where there
is any concern about the care given having contributed to the persons death.

Any person with any concerns about how or why someone has come to their death can contact the coroner directly. This will not change where a person subject to a DoLS authorisation. What will change is that the coroner will no longer be duty bound to investigate every death where the deceased had a DoLS in place (Chief Coroner, 2017)

5.3 Doncaster’s Coroner’s Out of Hours Referral Process

It is important that RNs trained to undertake the verification of expected death procedures, are aware of issues requiring a referral to the Coroner before proceeding with the procedure (section 5.2) and be prepared for situations that may only be identified during the verification process that subsequently require a referral to the Coroner. This can present difficulties for the RN, who at a sensitive time is supporting bereaved relatives but is required to inform the family and GP/doctor of a need to refer to the Coroner. The professional position outlined in the NMC ‘The Code’ states that ‘Each RN is responsible for his/her own actions and omissions regardless of advice or directions from another professional’ (NMC 2016).

For Community Nursing Services ONLY:

If at the time of referral for verification of an expected death the GP and RN identify a situation that requires a referral to the coroner (section 5.2), the RN may attend to undertake the verification procedure however the RN has the right to decline. If the RN attends then they must complete letter 2 (appendix 4) and send this to the requesting GP following verification. The Coroner requires the name of the healthcare professional who verified the death; please ensure this section of the letter is also completed. It is the requesting GP’s responsibility to complete all referrals to the Coroner and to contact South Yorkshire Police (section 5.4).

- If at the time of the verification of expected death procedure the RN identifies a situation that requires a referral to the Coroner, that was not known at the time of the GP referral (see list above) the RN is required to contact the requesting GP, highlight the identified concerns, recommend a referral to the Coroner and inform the requesting GP that they are unable to authorise the removal of the deceased to the funeral director. The RN will explain the situation to the relative/carers (details may be limited depending on reason for referral i.e. suspicious circumstances and complete a letter 2 (appendix 4) for the requesting GP who will complete the referral for the coroner.

- If the requesting GP disagrees with the rationale offered by the RN it is the requesting GP’s responsibility to visit the patient and verify that death has occurred and the RN will professionally request the GP to visit the deceased. If the GP declines the RN will escalate to their Line Manager for further advice.

For Hospice Inpatient Unit service ONLY:
• For coroner referral process – see Care after Death SOP.

5.4 South Yorkshire Police Response to Referrals to Doncaster Coroner

For Community Nursing Services ONLY:

When South Yorkshire Police receive a notification of a death requiring a referral to the Coroner in Doncaster the Police, irrespective of the time of day or night will:

• Liaise with family/relatives.
• Arrange to visit the home/residence of the deceased person to make a formal identification of the deceased with the family/relatives and
• Complete Gen 18 paperwork (Appendix 5)
• Explain the plan of action following their visit.
• Authorise the removal of the deceased to a specific funeral director and liaise with the Coroner’s officers. The Coroner’s officers will liaise with the relatives/carers and arrange further contact if required.

5.5 Verification of Expected Death Procedure (Community Services)

When an expected death occurs outside normal GP working hours the GP Out of Hours Service can contact an RN via the Single Point of Access (SPA) and request that an RN visit to verify that an expected death has occurred.

Acceptance criteria:

• The deceased MUST have been known to the RDASH Community Nursing Service for end of life care prior to death (community only)
• A valid DNACPR MUST be in place (Wilson, Laverty and Cooper, 2016)
• For nurse verification a doctor must have seen the patient in the last 14 days’.
• There is written documentation in the patients records (in a designated location) indicating that the patient is nearing the end of life.
• The deceased must reside within the Borough of Doncaster

Timely Verification

Best practice dictates that verification should be carried out in a timely manner as it is key to the grieving process, causes minimal distress and allows time to offer support to the family:

• In the community setting within 4 hours
• In the Hospice setting within 1 hour

The RN will:

• In a sensitive and supporting manner support the relatives/carers and
offer a full rationale for their contact and procedures that they are required to undertake

- Confirm the identity of the patient with the relative/carer/designated person
- Clarify any cultural requirements that may affect the verification procedures

If no contraindications are identified the RN can proceed with the verification process (Appendix 6). However the RN must not remove any parenteral or life prolonging equipment until after death has been verified and no suspicious circumstances are identified (Wilson, Laverty and Cooper, 2016). Furthermore it is an offence to remove or otherwise interfere with a body or surrounding evidence without leave of the Coroner where death has occurred in circumstances which may lead them to hold an inquest (Earland 2006)

- The RN must notify the funeral directors of any infections and implantable devices (ICD, Pacemaker). It is recommended that prior to death the RN arranges for an ICD device to be deactivated.
- It is the right of the RN to refuse to verify death and to request the attendance of the responsible doctor / police if there is an unusual situation (safeguarding issues, medication discrepancies). The procedure for an unexpected death must be followed (Transfer of the Deceased Patient Policy) and the RN must not authorise the removal of the body to the funeral directors.
- Verify that death has occurred following agreed procedures (appendix 1, 2, 6). Verification of death requires the RN to assess the patient over a minimum timeframe of 5 minutes to establish that irreversible cardio-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 five minutes observations (Wilson, Laverty and Cooper, 2016).

5.6 Verification of Expected Death Procedure (In Patient Services)

For Hospice Inpatient services: when an expected death occurs the RN will follow the verification of expected death procedures outlined in section 5.5. with the addition of:

- If the expected death occurs within normal working hours and the RN is aware that a referral to the Coroner will be required they will inform the relatives and notify the doctor on duty. The doctor should then liaise with the Coroner's office (using on-line form), explain to the relatives why a referral is required and the process regarding issuing a death certificate. It would be regarded as best practice to discuss referral to the Coroner with both the patient and the family prior to death when it is already known that a referral to the coroner will be required (industrial disease).
- If an expected death occurs during out of hours services and no issues are identified that require a referral to the coroner the RN, following
discussions with the relatives, can verify that an expected death has occurred and authorise the removal of the deceased. Ensure the doctor is informed as soon as possible i.e. the following morning if the death occurred during the night. The relatives will be asked to telephone the ward at an agreed time the next working day to arrange collection of a death certificate.

5.7 Record Keeping

The RN is required to ensure adequate records are maintained at all times in line with RDASH Health Record Keeping Standards and Health Records Management (2013) and NMC The Code (2016) Standards for Record Keeping.

- The RN who verifies that an expected death has occurred will clearly document in the patient’s records/care plan (EPaCCs) that they have completed the Verification of Expected Death procedure appropriate for their area (community, Hospice)
- The RN will explain to the relatives/carers what will happen next depending upon the situation encountered.

5.8 No Contraindications Identified

The RN will authorise the removal of the deceased to a funeral director identified by the relatives/carers and explain how the family/carers arrange to collect a death certificate from the patient’s GP surgery, complete Letter 1 (appendix 7) and send a copy to the patient’s GP’s surgery as soon as possible (community only).

- For Hospice Inpatient services, see section 5.6 for removal of the deceased following verification in and out of hours.
- The RN will explain how other agencies involved in the care of the deceased will be notified i.e. District Nurse/Specialist Nurses/Macmillan/Community Matron.
- The RN will provide information for relatives/carers i.e. ‘What to do after Death’ (Department of Work and Pensions, 2016)
- The RN will provide contact details of the RN who verified the death
- The RN will sign post to supporting information and follow up support as appropriate

5.9 Contraindications Identified that Require a Referral to the Coroner

- The RN will contact the requesting GP and advise that a referral to the coroner is required explaining the rationale for the decision made, complete letter 2 (appendix 4), explain the referral process and police involvement to the relatives/carers and send Letter 2 (appendix 4) to the requesting GP (community only).
For Hospice inpatient services see section 5.6.

6. TRAINING IMPLICATIONS

Verification of Expected Death Policy

<table>
<thead>
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<th>Staff groups requiring training</th>
<th>How often should this be undertaken</th>
<th>Length of training</th>
<th>Delivery method</th>
<th>Training delivered by whom</th>
<th>Where are the records of attendance held?</th>
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<tr>
<td>Registered Nurses undertaking Verification of Expected Death procedures</td>
<td>3 yearly</td>
<td>3 hours</td>
<td>Face to face</td>
<td>Community Practice Educators Nurse consultant - Hospice services</td>
<td>Electronic Staff Record system (ESR)</td>
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7. MONITORING ARRANGEMENTS

<table>
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<th>Who by</th>
<th>Reported to</th>
<th>Frequency</th>
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<tr>
<td>Standard IRI Reporting of incidents regarding issues relating to the verification of expected deaths</td>
<td>Number if IRI reports</td>
<td>Area Clinical Managers, Team Leaders Unit Managers, Modern Matrons.</td>
<td>Doncaster Care Group</td>
<td>quarterly</td>
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8. EQUALITY IMPACT ASSESSMENT SCREENING

The completed Equality Impact Assessment for this Policy has been published on this policy’s RDASH policy webpage

8.1 Privacy, Dignity and Respect

The NHS Constitution states that all patients should feel that their privacy and dignity are respected while they are in hospital. High Quality Care for All (2008), Lord Darzi’s review of the NHS, identifies the need to organise care around the individual, ‘not just clinically but in terms of dignity and respect’.

As a consequence the Trust is required to articulate its intent to deliver care with privacy and dignity that treats all patients with respect. Therefore, all procedural documents will be considered, if relevant, to reflect the requirement to treat everyone with privacy, dignity and respect, (when appropriate this should also include how same sex accommodation is provided).
8.2 Mental Capacity Act

Central to any aspect of care delivered to adults and young people aged 16 years or over will be the consideration of the individuals capacity to participate in the decision making process. Consequently, no intervention should be carried out without either the individuals informed consent, or the powers included in a legal framework, or by order of the Court

Therefore, the Trust is required to make sure that all staff working with individuals who use our service are familiar with the provisions within the Mental Capacity Act. For this reason all procedural documents will be considered, if relevant to reflect the provisions of the Mental Capacity Act 2005 to ensure that the interests of an individual whose capacity is in question can continue to make as many decisions for themselves as possible.

<table>
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<tr>
<th>Indicate How This Will Be Achieved</th>
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<tr>
<td>No impact as patients are deceased</td>
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9. LINKS TO ANY ASSOCIATED DOCUMENTS

- Transfer of the Deceased Policy, Clinical Policies, End of Life care, RDASH Intranet.
- Care of the Adult Patient following Death (Last Offices) SOP, Clinical Policies, End of Life care, RDASH Intranet.
- Safe and Secure Handling of Medicines, Clinical Policies, Medicines, RDaSH Intranet.
- Safeguarding Adults, Clinical Policies (General), RDaSH Intranet.
- Clinical Risk Assessment and Management Policy, Clinical Policies (General).
- Adults - Do not attempt Cardiopulmonary Resuscitation (DNACPR) policy, Clinical Policies (General), RDaSH Intranet.
- Clinical Policies (General), RDaSH Intranet.
- Decontamination Policy, Clinical Policies, Infection Control, RDaSH Intranet.
- Clinical Policies, Infection Control, RDaSH Intranet.
- Deprivation of Liberty Safeguards Policy – Mental Health Act Policies.
10. REFERENCES

- Department of Health The Mental Capacity Act (2005)
- Royal College of Nursing. Confirmation of Verification of Death by registered nurses. Available at www.rcn.org.uk (downloaded 3/2/17)
- Wilson, J, Laverty, D, Cooper, M (2016) Care after Death: Registered Nurse Verification of Expected Adult Death guidance. London, Hospice UK. Available at www.hospiceuk.org (downloaded 6/1/17)

11. APPENDICES

Appendix 1 Assessment Specification (Performance)
Appendix 2 Assessment Specification (Knowledge)
Appendix 3 RDASH Clinical Skills Assessment Tool
Appendix 4 Letter 2 Notification Procedure Following Verification for Community Services
Appendix 5 GEN 18
Appendix 6 Verification of Expected Death Pre-Checklist/Procedure/GP Communications
Appendix 7 Letter 1 No Contraindications
APPENDIX 1

ASSESSMENT SPECIFICATION (Performance)

AIM

The RN can competently and confidently verify that an expected death has occurred.

Competency – Performance

Competence Expectation

The Registered Nurse competently and confidently undertakes verification of expected death, and ensures that related documentation is completed.

Evidence Type:

1. Direct Observation
2. Questioning
3. Simulation
4. Reflective

Minimum equipment required
- Pen Torch
- Clock with second hand
- Stethoscope

Practice Record

Evidence of Performance Type of evidence

Date achieved:

Assessor:

1. Checks relevant patient records to ensure that death was expected and that the deceased had a DNACPR
2. Did the deceased require deactivation of an ICD?
3. Checks all necessary equipment is available and in working order
4. Confirms correct identity of the patient
5. Informs relatives/carers of verification process in a professional manner
6. Performs hand decontamination pre and post procedure
7. Maintains infection prevention and control standard precautions
8. Respects privacy, dignity, cultural and religious beliefs at all times
9. Lies deceased patient flat, leaves all tubes, lines, drains, medication patches and pumps in place (turning off pumps and fluids).

Stages 10, 11 and 12 should take place over a minimum of 5 minutes.

10. Confirms with stethoscope the absence of heart sounds for 1 minute
11. Confirms with stethoscope the absence of breath sounds for 1 minute
12. Confirms the absence of carotid pulse for 1 minute
13. Confirms pupils are fixed and dilate and unresponsive to light (cerebral function)
14. No reaction to a Trapezius muscle squeeze (cerebral function)
15. Safely disposes of medication, if required
16. Records physiological findings on EPaCCs
17. Records date, time that the expected death was verified (official time of death) on EPaCCs
18. Decontaminate equipment used in the process according to local policy
19. Authorise removal of the deceased to appointed funeral directors
21. Community - inform the GP using letter 1 (appendix 7),
APPENDIX 2

ASSESSMENT SPECIFICATION (Knowledge)

AIM

The RN can competently and confidently verify that an expected death has occurred.

Competency – Knowledge

Competence Expectation

The Registered Nurse competently and confidently undertakes verification of expected death, and ensures that related documentation is completed.

Evidence Type:-

1. Direct Observation
2. Questioning
3. Simulation
4. Reflective

Practice Diary

Evidence of Knowledge Type of Evidence

Date achieved:

Assessor:

1. Defines expected death
2. Explains the difference between verification and certification of death
3. Explains the difference between time of last breath and official time of death
4. Identifies situations when the death must be referred to the Coroner
5. Lists the patient details required to complete the procedure
6. Describes the equipment required for verifying an expected death
7. Explains the significance of:-

- Checking for responses to painful stimuli
- Checking the absence of heart sounds with a stethoscope for 1 minute
- Checking for the absence of carotid pulses for 1 minute
- Checking the absence of breath sounds with a stethoscope for 1 minute
- Confirming that pupils are fixed and dilated and unresponsive to light
- Checking the absence of response to the trapezius squeeze.
- Leaving tubes, lines and medication patches and pumps in place prior to verification
- Deactivation of the ICD device

8. Explains the circumstances when the verification of death must be carried out by a medical practitioner
9. Discussed the cultural/religious needs the patient or family may have at the time of death
10. Describes how to manage a patient with a known infectious disease at the time of death
11. Explains what should be documented following the verification of an expected death.
12. Explain what information the relatives/cares requires.
14. Explain communication systems used to ensure all professional are aware that a death has occurred.
## RDaSH Clinical Skills Assessment Tool

Name of Clinical procedural Skill: ____________________

### Simulation or patient (circle)

Name of participant: ____________________  Job title: ____________________  Place of work: ____________________

<table>
<thead>
<tr>
<th>Category</th>
<th>Areas of competence:</th>
<th>Met Not Met N/A</th>
<th>Areas for improvement/omissions</th>
<th>Areas of good practice</th>
<th>Level 0,1,2,3,4,5</th>
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<tr>
<td><strong>Pre-procedure</strong></td>
<td>ID, consent and discussion,</td>
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<td>Hand hygiene and PPE</td>
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<td>Patient position and dignity</td>
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<td><strong>Procedure</strong></td>
<td>Safe/effective use of equipment</td>
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<td>Involve patient as appropriate</td>
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<td>Safe disposal of equipment as appropriate</td>
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<td><strong>Post-procedure</strong></td>
<td>Expected outcome</td>
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<td>Documentation and record keeping</td>
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<td>IPC/decontamination</td>
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<tr>
<td><strong>Dealing with complications</strong></td>
<td>Identify complications, seek timely advice</td>
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<td></td>
<td>Action to Rectify</td>
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<td>Reporting/record keeping</td>
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### Reflection

Learner to sign once given feedback: ____________________

| Learner to sign once given feedback: ____________________ |

### Final Assessment

Final Assessment: Y / N

### Action Plan

Action Plan

### Assessor Name and Sign

Assessor Name: ____________________  Assessor Sign: ____________________  Assessor Qualifications:  

Date: __________

Print Name) (Signature)

RDaSH Clinical Skills Assessor: Y / N
LETTER 2

Notification Procedure Following Verification for Community Services

CONTRAINDICATIONS HAVE BEEN IDENTIFIED

Name of GP
Address
Address
Address
Tel Number
Fax number

Date

Dear

Name of Patient:
Address:
Date of Birth:
NHS Number:

I saw this patient on --------------at -------------- hours and verified that death had occurred.

I am referring this patient back to you as per The Verification of Expected Death Policy for the following reason/s:

• -----------------------------------------------------------------------------------------------

• -----------------------------------------------------------------------------------------------

I have therefore not authorised the removal of the body by the undertakers.

The Coroner requires the details of the healthcare professional who verified death, please can you add this to you Coroner referral.

Verification of Expected Death by:________________________

Yours sincerely

Name
Position
Location
APPENDIX 5

GEN 18

SOUTH YORKSHIRE POLICE

Report of Death

To: H.M. CORONER Officer………………………………………………………………………………

Sub – Division………………………………………

1. Particulars of Deceased

Full name: If married woman include married and maiden name:

Permanent address:

Occupation:

Date and place of birth:

Age:

Marital status:

Date of birth:

Name and address of surviving spouse:

Telephone no:

Name and address of contact if different from above:

If deceased was a married woman or widow, give name and occupation of husband:

If deceased was 15 or under, give name and occupation of both parents or guardian:

2. Medical History

Name, address and telephone of deceased’s own doctor:

When was deceased last seen by own doctor?

3. Identification

By whom: If different to above, state relationship, name, address and telephone no:

Is own doctor prepared to certify cause of death? YES/NO

To whom identified:

Date and time of death:

Place of death:

Body now at:

By whom removed:

Name of doctor pronouncing life extinct:

4. Name and address of undertaker:
APPENDIX 6

Verification of Expected Death Pre-Checklist/Procedure/GP Communications
(Community)

Please obtain YES or NO responses to the following questions

- Is the patient known to community nursing service (check records)
- Does the patient have a DNACPR (check records)
- Is it documented in the patient records that patient is nearing the end of life (check records)?
- Has the GP seen the patient in the last 14 days?

NO CONTRAINDICATIONS
If no contraindications are identified proceed with the verification procedure.

No contraindications YES/ NO (Please circle YES or NO)

By verifying that death has occurred have you:

1. Check relevant patient records to ensure that death was expected and that the deceased had a DNACPR insitu.
2. Any cause for concern?
3. Does the deceased require deactivation of an ICD?
4. Check all necessary equipment is available and in working order.
5. Confirm correct identity of the patient
6. Inform relatives/carers of verification process in a professional manner
7. Perform hand decontamination pre and post procedure
8. Maintain infection prevention and control standard precautions
9. Respect privacy, dignity, cultural and religious beliefs at all times
10. Lie deceased patient flat, leaves all tubes, lines, drains, medication patches and pumps insitu (turning off pumps and fluids).

Stages 11, 12 and 13 should take place over a minimum of 5 minutes.

11. Confirm with stethoscope the absence of heart sounds for 1 minute
12. Confirm with stethoscope the absence of breath sounds for 1 minute
13. Confirm the absence of carotid pulse for 1 minute
14. Confirm pupils are fixed and dilate or unresponsive to light (cerebral function)
15. No reaction to a Trapezius muscle squeeze (cerebral function)
16. Safely dispose of medication, if required and records on patient records
17. Record physiological findings on EPaCCs
18. Record date, time that the expected death was verified (official time of death) on EPaCCs
19. Decontaminate equipment used in the process according to local policy
20. Authorise removal of the deceased to appointed funeral directors

CONTRAINDICATIONS IDENTIFIED

If contraindications are identified inform the appropriate person i.e. GP, recommend a referral to the coroner, agree appropriate person to verify death and send Letter 2 (Appendix 4).

If RN is to verify the death - follow the procedure above but:

IF CONTRAINDICATIONS IDENTIFIED DO NOT AUTHORISE THE REMOVAL OF THE DECEASED TO THE FUNERAL DIRECTOR THIS IS THE RESPONSIBILITY OF THE POLICE.

Staff Signature:
Print Name:
Designation:
Date of Verification:
Time of Verification (24 hour clock):

COMMUNITY - PLEASE FILE IN PATIENT NOTES AND RECORD IN PATIENT NOTES/ELECTRONIC RECORDS THAT A VERIFICATION OF EXPECTED DEATH CHECKLIST HAS BEEN COMPLETED
LETTER 1 – No Contraindications

Notification Procedure Following Verification of an Expected Death for Community Services

Name of GP
Address
Address
Address
Tel number
Fax
Date

Dear

Name of Patient:
Address:
Date of Birth:
NHS Number:

I saw this patient on ------------ at --------- hours and verified that an expected death had occurred (certifiable).
I have therefore authorised the removal of the body by the undertaker and asked the family/carer to contact your surgery between 08.30 and 10.00am on -------- to discuss certification.

Yours sincerely

Name
Position
Location
Page