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**VERIFICATION OF EXPECTED DEATH OF ADULTS  
BY REGISTERED NURSES POLICY – Please note amendments made for interim period during Covid  
19 National Emergency**

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*Solent NHS Trust policies can only be considered to be valid and up-to-date if  
viewed on the intranet. Please visit the intranet for the latest version.*

Purpose of Agreement	This policy provides a framework for the verification of an inevitable and expected death by a competent Registered Nurse within Solent NHS Trust
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### Amendments Summary:

Amend No	Issued	Page	Subject	Action Date
1a	Apr 16	3	Addition of executive summary	Apr 16
1b	Apr 16	5	Clarification of 1.3.5	Apr 16
1c	Apr 16	6	Addition of 2.3 , 4.3, 4.4, 4.5 and 4.6	Apr 16
1d	Apr 16	7	Change to 5.3, minor re-wording	Apr 16
1e	Apr 16	8, 9	6.3 change to appendices numbering, minor re-wording	Apr 16
1f	Apr 16	Appendix 1	Addition of appendix	Apr 16
1g	Apr 16	Appendix 4 and 5	Addition of NMC number	Apr 16
2a	July 19	Summary	Minor change and addition of Portsmouth SOP	Aug 19
2b	July 19	6	New scope wording, addition of DOLS advice, some definitions clarified	Aug 19
2c	July 19	7	Additional excluded issue of patient not at home etc., 4.15 deleted,, references updated	Aug 19
2d	July 19	8	4.2.6-8 updated	Aug 19
2e	July 19	9	Addition of trapezius squeeze	Aug 19
2f	July 19	10	Amendment to allow competencies to be completed in real work activity, deletion of 6.5 (TNA), addition of DOLS statement	Aug 19
2g	July 19	App 1	Rewritten as updated guidance	Aug 19
2h	July 19			Aug 19
2i	July 19			Aug 19
2j	July 19			Aug 19
2k	21 April 2020		Summary of new legislation contained at page 3	April 2020
2L			Changes relate specifically to 1.4.1	April 2020
2m			Changes relate specifically to 3.2	April 2020
2n			Changes relate specifically to section 4.2 and section 5.0 replacing all references to Nursing responsibilities and nursing to refer to Registered Health Professional	April 2020
2o			Change to 5.8.2 Organ donation	April 2020

## Review Log:

Version Number	Review Date	Lead Name	Ratification Process	Notes
2	Sept 2012	Sarah Osborne	Verification of Death Working Party Governance groups Policy Group	Revised version of existing Portsmouth Policy
3	April 2016	Sarah Osborne	Reviewed by staff in Southampton and Portsmouth	Updated version
4	July 2019	Sarah Osborne	Routine review	
4.1	April 2020	Angela Anderson, Associate Nurse Director	Changes made in response to Covid 19 National Emergency and temporary changes in legislation. Changes agreed through Quality Impact Assessment (QIA)	
4.2	November 2020	Angela Anderson	Confirmed extension of temporary changes to July 2021, as National Guidance has not changed. Approved via Policy Steering Group.	

*Staff are expected to adhere to the processes and procedures detailed within this policy. During times of national or 'Gold command' emergency Solent NHS Trust may seek to suspend elements of this policy in order to appropriately respond to a critical situation and enable staff to continue to work in a way that protects patient and staff safety. In such cases Quality Impact assessments will be completed for process changes being put in place across the organisation. The QIA will require sign off by the Solent NHS Ethics Panel, which is convened at such times, and is chaired by either the Chief Nurse or Chief Medical Officer. Once approved at Ethics panel, these changes will be logged and the names/numbers of policies affected will be noted in the Trust wide risk associated with emergency situations. This sign off should include a start date for amendments and a review date or step down date when normal policy and procedures will resume.*

## Verification of death: Summary of key changes in legislation due to Covid 19

Verification of an expected death can be by a Registered Health Professional in a community or inpatient setting (see 4.2). Previously this was only performed by a Registered Nurse. This has now been extended to include other registered health professionals for example physiotherapists and occupational therapists. Training will be provided to staff who have not previously undertake this practice and who it is identified will be required to carry this out during the National Emergency. It is normally expected that a Do Not Attempt Cardiopulmonary Resuscitation Order or Respect form is in place, however in exceptional circumstances e.g. during the COVID-19 outbreak this may not be possible (please see page 6, Executive Summary below)

### **Personal Protective Equipment**

Following the COVID-19 outbreak additional measures should be followed in relation to the use of Personal Protective Equipment (PPE). A fluid resistant mask should also be used in addition to standard precautions gloves and apron (as well as eye protection where there is a risk of contamination of eyes by splashes or droplets) when verifying death and carrying out care after death.

### **Medical certification (information for medical practitioners)**

There are temporary changes in relation to the way in which deaths can be certified during this period. Existing statutory requirements imposed upon registered medical practitioners to certify medical cause of death have been revised significantly in the light of the current national coronavirus emergency.

Previously the requirement was that any registered medical practitioner was required to provide a certificate provided s(he) had attended upon the deceased in their last illness and had last seen the deceased within 14 days of death or after death.

Schedule 13 of the Coronavirus Act 2020 which has received the Royal Assent is now law and considerably revises and relaxes this regime principally in the following ways:-

- First by virtue of s4(2) of Schedule 13 to the Act, a registered medical practitioner who is not the practitioner who attended the deceased during the deceased's last illness may nevertheless provide a certificate provided it is "impractical" for the attending registered practitioner to do so and the signing practitioner is able to state to the best of his (her) knowledge and belief the cause of death.
- Second, by virtue of s4(3) a registered medical practitioner may sign a certificate even in the case of a person who has not been attended by a registered medical practitioner during that person's last illness at all provided the RMP is still able to state to the best of his knowledge and belief the cause of death.
- Third by virtue of s6(3)(b) the period of time within which an attending RMP may have seen the deceased prior to his or her death is extended from 14 to 28 days. (see section 1.4.1 & 4.1.4)
- Finally s19 of the Coronavirus Act removes the need for a confirmatory medical certificate prior to a cremation (Form crem 5 no longer needed).

Whilst these revisions considerably relax the previous statutory requirements, nevertheless it remains incumbent upon any signing practitioner to satisfy themselves that they can certify the cause of death to the best of their knowledge and belief. The appropriate doctor completes the MCCD as soon as possible.

COVID-19 is an acceptable direct or underlying cause of death for the purposes of completing the Medical Certificate of Cause of Death

COVID-19 is not a reason on its own to refer a death to a coroner under the Coroners and Justice Act 2009

COVID-19 is a notifiable disease under the Health Protection (Notification) Regulations 2010 does not mean referral to a coroner is required by virtue of its notifiable status

### **Registration of death**

There are temporary changes in relation to the way in which deaths are registered during this period.

The Coronavirus Act (2020) has removed the requirement for a death or still-birth informant to attend the registration in person. They will not be expected to attend an office in person; a Registrar will contact them at the appointment time to complete the registration over the telephone. Although Family members are still preferred to register a death, Funeral Directors have been temporarily added to the list of qualified informants, where they are acting on behalf of a Family. A “wet” signature is still required on the original document and medical practitioners must keep all original documents so they can be sent to the Register Office after the emergency period. (Coronavirus Bill: Managing the Deceased Briefing Paper No 08860 2th March 2020 House of Commons Library)

**Organ / tissue donation during COVID-19 outbreak**

Following the current COVID-19 outbreak it is unlikely that tissue / organ donation is an option due to the potential for active systemic viral infection. It is important to check for the latest guidance as this is subject to change ([see 5.8.2](#))

### **Verification of Death Policy Executive Summary:**

- This policy outlines the requirements for Registered Health Professionals to be able to verify patients' death
- A death can only be verified by a Registered Health Professional if:
  - The death is expected, has been recorded as such by a Medical Practitioner in the patient's records and there is a valid Do Not Attempt Cardiopulmonary Resuscitation order in place (during Covid 19 National Emergency this may not always be possible)
  - There is a Registered Health professional available who has been deemed competent to undertake verification
  - The patient is known to the Clinical Team
  - There are no legal reasons why verification cannot take place
- Verification must follow the process outlined in this policy to ensure that life is extinct
- Verification must be recorded using the form included in this policy or as per local procedure
- Following verification, the Registered Health Professional must ensure that appropriate care after death is carried out, any relatives/next of kin are informed and the patients' medical practitioner or out of hours doctor is informed in order that a Medical Certificate of Cause of Death can be produced

NB: Portsmouth has an aligned SOP to outline the local procedures for recording as the GPs in the area use SystemOne for recording expected deaths. In Southampton, not all GP surgeries are on SystemOne so the GP would record in their record and the Community Nursing team record on SystemOne.

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## VERIFICATION OF EXPECTED DEATH OF ADULTS BY REGISTERED HEALTH PROFESSIONALS POLICY

### 1. INTRODUCTION & PURPOSE

1.1 For Clinical teams who provide care to adult patients at the end of their life, being able to verify an expected death will allow them to provide appropriate after care to relatives and carers and continuity at a time of stress and anxiety.

1.2 The expected outcomes of this policy are:

- The death of the patient is dealt with in a timely, sensitive and caring manner, respecting the dignity of the patient and their relatives and carers
- The death of the patient is dealt with in accordance with the law
- There is appropriate use of Registered Health Professionals skills and competencies
- Reduction in delays following a patient's death
- Prevention of unnecessary emergency ambulance or Out of Hours GP call outs

1.3 This document will be available on the Trust Intranet and in relevant clinical areas. All new staff should be made aware of this procedure during induction into the workplace and will receive appropriate training as required to confirm death within their role

1.4 Legal position:

1.4.1 Certification of death is the process of completing the "Medical Certification of Cause of Death" which must be completed by a Medical practitioner who has attended the deceased during the last illness (they should have seen the patient in the 28 days preceding death)

1.4.2 Confirmation or verification of the fact of death does not require a medically registered practitioner

1.4.3 The certificate details cause of death and should be issued within 24 hours or the next working day following the death, by the medical practitioner

1.4.4 The medical practitioner does not have to view the body of the deceased person prior to issuing the certificate and does not have to report the death if it is an expected death, unless it is reportable (see Appendix 1)

1.3.5 Certain reportable deaths may still be verified by a non-medical practitioner including deaths due to Industrial disease, related to a patient's employment or following a surgical procedure or significant injury in the previous 12 months. It is recommended however, that in such cases verification is discussed with the patients' medical practitioner and the results of that discussion recorded in the patient record

## 2. SCOPE & DEFINITIONS

- 2.1 This policy applies to locum, permanent, and fixed term contract employees who hold a contract of employment or engagement with the Trust, and bank staff, Non-Executive Directors and those undertaking research working within Solent NHS Trust, in line with Solent NHS Trust's Equality, Diversity and Human Rights Policy. It also applies to external contractors, agency workers, and other workers who are assigned to Solent NHS Trust.
- 2.2 Solent NHS Trust is committed to the principles of Equality and Diversity and will strive to eliminate unlawful discrimination in all its forms. We will strive towards demonstrating fairness and Equal Opportunities for users of services, carers, the wider community and our staff.
- 2.3 This policy relates to verification of death for adult patients over the age of 18 only
- 2.4 If a patient was under a Deprivation of Liberty Safeguard (DOLS), this will no longer have an effect on whether death can be Verified, and the patient can be treated under the Policy

### 2.5 DEFINITIONS

- 2.5.1 **An expected death** is a death where a patient's demise is anticipated in the near future. For verification of death to occur, this must have been recorded in the patient record
- 2.5.2 **Inevitable expected death** is a death following on from a period of illness that has been identified as terminal and where no active intervention to prolong life is ongoing. The patients GP/Doctor will have attended during this illness
- 2.5.3 **Verification of death** is the procedure of determining whether a patient has died. All deaths should be subject to professional verification (Secretary of State for the Home Department, 2003). It is separate to the certification process and can be performed by either a medical practitioner or other suitably qualified professional
- 2.5.4 **Certification of death** is the process of completing the Medical Certificate of cause of death and can only be carried out by a medical practitioner according to rules defined by the Births and Death Registration Act 1953 where the doctor has seen the patient within the last illness, ideally within the last 14 days of life (Home Office 1971, Hospice UK 2019)
- 2.5.5 **Confirmation of death** - for the purposes of this document, the term Verification of death is used, but this is interchangeable with the term Confirmation of death

## 3 EXCLUDED ISSUES

- 3.1 Any death which is not expected or which raises concerns
- 3.2 Any death where the medical practitioner has not attended the patient during their last period of illness and has not formally identified a patient as expected to die
- 3.3 The patient is not known to the clinical team being asked to verify death

3.4 An expected death where death has occurred in an unexpected manner or the circumstances provide a cause for concern

3.5 The death has not occurred in the patient's residence, a hospice, hospital, residential or Nursing Home or prison

#### **4 ROLES & RESPONSIBILITIES**

##### **4.1 Medical responsibilities:**

4.1.1 The patient's GP or doctor will formally identify patients whose death is expected and record this in the patient record. The doctor will communicate with the nursing staff regarding those patients identified as an expected death and confirm whether s/he has agreed to allow the nursing team to confirm death

4.1.2 Will discuss verification of death, and consider the views, if appropriate, of the patient, relatives and nursing staff responsible for the patient

4.1.3 The doctor of the deceased patient will complete the death certificate at the first reasonable opportunity in readiness for collection by relatives. Exceptions to this will occur when an expected death must be reported to the Coroner e. g. death due to asbestos related disease. In such cases, the medical practitioner will inform the Coroner

4.1.4 Will ensure they have attended the patient during the last expected illness, ideally within 28 days of the expected death

##### **4.2 Registered Health Professional:**

4.2.1 Registered Health Professionals (RHPs) will acknowledge the limits of their professional competence and only undertake practice and accept responsibilities for those activities in which they are competent and act according to the Nursing and Midwifery Council Code (NMC 2018) and Health Care Professionals Council (HCPC)

4.2.2 All RHPs confirming death must have the competencies, skills and knowledge to enable them to determine the physiological aspects of death. It is expected that staff undertaking this procedure will have the necessary competencies and experience to do so

4.2.3 The RHP should be aware of the legal issues and accountability that relate to this extended scope of professional practice. Training to achieve these competencies will be provided by the Trust

4.2.4 The RHP verifying death must inform the medical practitioner of the death

4.2.5 A member of the primary care/clinical team should always be prepared to speak to relatives when they verify death and/or when the certificate is collected, if appropriate

4.2.6 The person Verifying death, including a RHP must inform the Funeral Director or Mortuary if there is a risk of infection, radioactive implants, implanted devices and active implanted cardiac defibrillators

- 4.2.7 The RHP must refuse to verify death and request the attendance of a medic or the police if the situation of the death is unusual
- 4.2.8 The decision that the patient is expected to die and that verification of death can occur should be recorded in the Anticipatory Care Plan in addition to the main body of the patient record

## 5 THE PROCESS

### 5.1 The RHP should

- 5.1.1 Ensure the patient's records reflect that the death is expected
- 5.1.2 Note the exact time of death or the time that the patient was found, and who found the patient
- 5.1.3 Check for clinical signs of death, using a stethoscope and penlight or ophthalmoscope
- 5.1.4 Confirm and record cessation of circulatory and respiratory systems and cerebral function. These should be checked for a minimum of one minute and then a second check for a minimum of one minute after five minutes have elapsed. A recording form is given as appendix 2
- 5.1.5 The following are the recognised clinical signs used when verifying death:
- Cessation of circulatory system
    - No carotid pulse
    - No heart sounds – verified by listening with a stethoscope for a minimum of 1 minute, repeated after 5 minutes
  - Cessation of respiratory systems
    - No respiratory effort
    - No chest sounds – verified by listening for a minimum of 1 minute, repeated after 5 minutes
  - Cessation of cerebral function
    - Pupils fixed and dilated
    - Pupils not reacting to light
    - No eye movements
    - No response to trapezius squeeze

If the results are inconclusive, repeat after 5 minutes. If still inconclusive contact the patients GP or Doctor for Verification.

### 5.2 Following verification of death:

- 5.2.1 The RHP must record in the patients' records:
- The date of death
  - The time of death or time the patient was found

- Identity of any person present at the death or, if the deceased was alone, the person who found the body.
- Time of verification
- Place of death
- Clinical signs of death
- Name of doctor informed and the time and date this took place
- Confirmation of the identification of the deceased person using the term “identified to me as...”

5.3 A form for recording verification is included as Appendix 2

5.4 The record of the RHP’s visit should be formally communicated to the patient’s GP as soon as possible: to the surgery during normal working hours and to the Out of Hours Service at other times, who should notify the GP by Fax the next working day. It is recommended that the verifying RHP checks that the GP has been made aware at the first available opportunity

5.5 The RHP should advise the deceased’s relatives that, except in exceptional circumstances, the patient’s own doctor will issue a medical certificate of the cause of death within 24 hours of the patient’s death, except at weekends and bank holidays when the certificate should be produced on the next working day

5.6 Parenteral drug administration equipment or any life prolonging equipment should not be removed prior to confirmation of death, but may be removed after verification except in the case of deaths reported to the coroner (see appendix 1). Batteries may be removed from electronic equipment, and equipment stopped in all cases

5.7 Advise relative or next of kin that the patient has died and give immediate emotional support and information regarding what to do after death

## 5.8 Organ donation

5.8.1 The NHS Blood and Transplant service has a 24 hour national helpline available for advice on 0300 123 23 23 or via [www.nhsbt.nhs.uk](http://www.nhsbt.nhs.uk)

5.8.2 When a person dies at home, tissue donation may be able to be made depending on diagnosis and cause of death but it is not possible to donate organs. This will have been pre-arranged and documented in the patient’s record. Due to the potential for active systemic viral infection it is unlikely during Covid-19 outbreak that tissue/organ donation is an option.

5.8.3 Tissue including corneas, skin and bone can be made by a patient of any age, within 24 hours of death, donation of heart valves, by patients up to age 60, can be made within 48 hours of death

## 6 EDUCATION AND TRAINING

6.1 Training will focus on the following areas:

- Legal aspects
- Skills of verifying death
- Application of the policy
- Meeting the needs of relatives and carers

6.2 Training will comprise a session comprising theoretical input followed by an observation assessment of competency. This may be completed in the classroom setting

6.3 A copy of the competency framework is included as appendix 3, the competency worksheet as appendix 4 and the worksheet notes as appendix 5

6.4 Update sessions will be run if staff identify to their line manager that their competencies have not been maintained by undertaking the procedures contained in this document

## **7 EQUALITY IMPACT ASSESSMENT AND MENTAL CAPACITY**

7.1 As part of the development of this Policy, an Equality Impact assessment was completed. A copy of this assessment is attached as Appendix 6. The result of this assessment was “no negative impact”

7.2 As stated above, a patient who was subject to a DOLS, is still able to have their death verified under this policy

## **8 SUCCESS CRITERIA/MONITORING EFFECTIVENESS**

8.1 There is a suggested audit form which services may wish to use as appendix 8

8.2 Any non-compliance with this policy must be reported using the non-compliance form found in the Policy on Procedural Documents Policy on the intranet

## **9 REVIEW**

9.1 This document may be reviewed at any time at the request of either staff side or management but will automatically be reviewed 3 yearly unless organisational changes, legislation, guidance or non-compliance prompt an earlier review

## **10 LINKS TO OTHER DOCUMENTS**

This policy links to:

- Deprivation of Liberty Standards and Mental Capacity Policy
- Unified Do Not Attempt CPR Policy
- Management of Resuscitation Policy
- Information Governance Policy
- Advanced Decision to Refuse Treatment Policy

## **11 REFERENCES**

Academy of Medical Royal Colleges 2008, Associated code of practice for diagnosis and confirmation of death

British Medical Association, January 2019 Confirmation and Certification of Death

Home Office 2001, Report of the Home Office Review of Death Certification, Executive Summary and Recommendations

Hospice UK April 2015, Updated Guidance for Professionals who provide Care After Death

Ministry of Justice February 2014, Guide to Coroner Services

National End of Life Programme and National Nurse Consultant Group (Palliative Care), 2011, Guidance for staff responsible for care after death

NICE Quality Standard 13, March 2017, End of Life Care for Adults

NMC October 2018 The Code: Standards of practice and behaviour for Nurses and Midwives

RCN July 2019, Confirmation of Expected Deaths by Registered Nurses, Royal College of Nursing

The Shipman Enquiry, 2003, Third Report – Death Certification and the Investigation of Deaths by Coroners.

### Reportable Deaths

Deaths must be reported to the Coroner by the Medical Practitioner or the Police in the following circumstances (NB only relevant circumstances are given):

- no doctor saw the deceased during his or her last illness
- although a doctor attended the deceased during the last illness, the doctor is not able or available, for any reason, to certify the death
- the cause of death is unknown
- the death occurred within 24 hours of admission to hospital
- the death occurred during an operation or before recovery from the effects of an anaesthetic
- the death was due to industrial disease or poisoning
- the death was sudden and unexplained
- the death was unnatural
- the death was due to violence or neglect
- the death was in other suspicious circumstances; or
- the death occurred in prison, police custody or another type of state detention
- the deceased was detained or was a voluntary patient under the Mental Health Act 1983
- the death occurs within 1 year of surgery and the cause of death is implicated to the medical procedure/treatment (whether invasive or not)

### Nurse Verification of an Expected Death

The patient has been identified to me as:

**Patients Name:**

**Date of Birth:**

**Address:**

**GP:**

**NHS No:**

Place of Death:	Time:	Date:	
Persons present at death/person who found the deceased* * please delete as appropriate			
Patient has died in the absence of a doctor	Yes	No	
GP has documented in patients notes that consent given for nurse verification of expected death	Yes	No	
Patient is known to the primary care team	Yes	No	
<b>Clinical signs</b>		<b>Initial</b>	<b>5mins</b>
No response to painful stimuli (e.g. sternal rub) confirmed?			
Absence of carotid pulse over one minute confirmed?			
Absence of heart sounds over one minute confirmed?			
Absence of respiratory movements and breath sounds over one minute confirmed?			
Fixed dilated pupils (unresponsive to bright light) confirmed?			
Relative or carer present If not present have they been notified	Yes Yes	No No	
Name of person informed: Relationship to patient: Contact Number:			
GP/Out of Hours informed (name of doctor)		Time informed	
Name of Nurse verifying death			
Signature			
Date and time of verification			
Status			

<b>In the event of the patient having drugs administered continuously via a syringe driver complete the following:</b>			
Infusion removed from (state site)			
Name of drug(s)			
Amount of fluid remaining in syringe			
Set up at (date and time)			
<b>I confirm the infusion was calculated and was delivering the correct amount.</b>			
<b>I confirm that the contents of the syringe have been made unusable</b>			
Verified by		Witnessed by	
Name		Name	
Signature		Signature	
Status		Status	
Date		Date	
Time		Time	

### Competency Framework for Registered Nurse Verification of Expected Adult Death in the Community Setting

Name..... Date of completion .....

Competency	Trainers signature	Date
The Registered nurse demonstrates a clear understanding of their own responsibilities and accountabilities including legal implications for nurse verification of expected death		
The registered nurse can advise on the relevant documentation and equipment required to complete the verification		
Is able to recognise potential clinical signs of death		
Can locate the carotid pulse		
Can use a stethoscope to listen for heart sounds		
Can use a stethoscope to listen for breath sounds		
Demonstrates the ability to examine the response of the pupil to light		
The registered nurse is able to indicate anatomical regions suitable to administer painful stimuli and assess response		
The registered nurse demonstrates completion of relevant paperwork and actions following examination		

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

**Name of assessor:** .....

**Signature of assessor:** .....

**Date:** .....



### Competency Worksheet Notes

1. Ensure the registered nurse's name is recorded on sheet.
2. Date of completion of competency important, from that date the nurse is deemed competent to carry out this procedure if required and that she/he is happy to do so.
3. It is important that the nurse has an awareness of why the training is needed and the background to it. This should include:
  - Improving end of life care for patients.
  - The reduction of delays that lead to distress for relatives
  - The prevention of potentially distressing and unnecessary ambulance call outs where resuscitation would be inappropriate.
4. Consider:
  - Who wants to be present
  - Their understanding of the nurse's role
  - Any language or communication barriers that will impede the understanding of the key persons involved
  - Privacy and prevention of interruption.
5. Legal implications - The RCN guidance should be quoted so the assessor is certain the nurse has full awareness of their role.
6. List equipment required: - stethoscope, torch, patient notes, all documentation pertaining to the procedure.
7. Checking identity - ensure that this is the patient, according to local guidelines. (name, address, NHS number, date of birth)
8. Check no signs of life: observation of the chest, calling their name, holding their hand to stimulate a response.
9. Check where a carotid pulse can be found, and other reasons why it may be difficult to find. The nurse to indicate where their carotid pulse is.
10. Use of a stethoscope - ensure nurse knows how to use one and where heart sounds should be heard, and to listen to their own
11. Use of stethoscope - nurse to show where breath sounds can be heard and to listen to his or her own.
12. Examination of pupils-why they are fixed and dilated, nurse to demonstrate how this would be carried out.

13. Considerations for the completion of the procedure:

- Ensure written documentation is completed in line with Trust Policy
- Last offices are undertaken according to policy and procedure
- The primary health care team/GP is notified of the death
- The patient's death is communicated to appropriate services across organisations
- The relatives/carer can express an understanding of what they will need to do next and are given relevant written information

Once the trainer/assessor is happy that the nurse is competent they can sign off the competency. In some circumstances this can take more than one attempt. Competency can also be achieved in real work activity by a joint visit to verify a death.

## Equality Impact Assessment

1. What are the main aims and objectives of the document?	This policy sets out the required standard to be delivered by Solent NHS Trust staff for verifying expected death		
2. Who will be affected by it?	All Registered nurses who train to perform Verification of death and verify death. Patients who are at end of life and expected to die and those important to them		
3. What are the existing performance indicators/measures for this? What are the outcomes you want to achieve?	Portsmouth Solent staff currently verify and the process is being rolled out across Southampton. This is an update of a current policy which was due for updating.		
4. What information do you already have on the equality impact of this document?	There have been several versions of the Policy in use, with no impact noted		
5. Are there demographic changes or trends locally to be considered?	Increasingly frail, elderly population  Increasing numbers of patients wishing to die at home		
6. What other information do you need?	None		
<b><u>Step 2 - Assessing the Impact; consider the data and research</u></b>	<b>Yes</b>	<b>No</b>	<b>Answer</b>  (Evidence)
1. Could the document unlawfully discriminate against any group?		x	
2. Can any group benefit or be excluded?	x		Only exclusions are those outlined in the policy. Verification of death by Registered Nurses will only occur if there are appropriately trained staff available
3. Can any group be denied fair & equal access to or treatment as a result of this document?		x	Generic Policy for all appropriate patients with proviso of appropriate availability of staff
4. Can this actively promote good relations with and between different groups?	x		Promotion of improved care and communication at end of life for appropriate patients
5. Have you carried out any consultation internally/externally with relevant individual groups?	x		Community and Inpatient staff via Matrons  Also, Nurse Verification of

			expected death is seen as good practice nationally (NICE, RCN, Hospice UK)
6. Have you used a variety of different methods of consultation/involvement	x		E-mail, Governance meetings
<u>Mental Capacity Act implications</u>			
7. Will this document require a decision to be made by or about a service user? (Refer to the Mental Capacity Act document for further information)	x		Decisions made by/on behalf of the patient will have been recorded prior to their death
<u>External considerations</u>			
8. What external factors have been considered in the development of this policy?	x		Internet search for updated information and guidance
9. Are there any external implications in relation to this policy?	x		Incorporated into the Policy
10. Which external groups may be affected positively or adversely as a consequence of this policy being implemented?		x	None

If there is no negative impact – end the Impact Assessment here.

## Suggested audit tool Verification of Expected Death

<b>Name of area/service</b>	
<b>Date of audit</b>	
<b>Time frame covered by audit</b>	
<b>Number of staff who have attended verification of expected death training</b>	
<b>Number of staff who have completed verification of expected death training competencies</b>	
<b>Number of patients whose death has been verified</b>	

An extension audit could be completed to check accurate completion of the verification form (Appendix 2)