The Newcastle upon Tyne Hospitals NHS Foundation Trust

Nurse Verification of Adult Expected Death Policy

| Version No: | 6.1 |
| Effective from: | 10 May 2017 |
| Expiry Date: | 14 November 2018 |
| Date Ratified: | 09 May 2017 |
| Ratified by: | Care of the Dying Patient Sub Group |

1 Introduction

The intention of this policy is to support Registered Nurses employed by Newcastle upon Tyne Hospitals in verifying expected death for those adult patients with a palliative diagnosis. Historically verification has been carried out by Medical Practitioners; however, in recent years there has been an acknowledgement that a Registered General Nurse who has undertaken education and has been assessed to be competent can perform this role. There are circumstances where a patient’s death is inevitable and it is appropriate to pronounce that death has occurred for the purpose of advising relatives and tending to and moving the body. Certification of death is the legal responsibility of the patient’s Medical or General Practitioner.

2 Policy Scope

This policy will be of primary interest to all clinical staff and will be most relevant in community settings and only in acute areas where a Doctor is not resident on site, for example, Cherryburn at The Campus for Ageing and Vitality.

The Trust expects that all NMC registered Nurses including agency and bank staff employed by the Trust who are involved in the verification of an expected adult death should adhere to the principles of this guideline.

Following the completion of Nurse Verification of Expected Death education and demonstrated competency, NMC Registered Nurses, working within the scope of the Nursing and Midwifery Council Code (2015), have the authority to verify expected death, notify relatives and advise them on the removal of the patient’s body by the undertaker. When indicated, the nurse is empowered to follow the procedure to notify the coroner.

3 Aim of Policy

- The purpose of this protocol is to provide a safe framework to enable qualified and competent nursing staff to verify adult expected death.
- To ensure the practitioner has the appropriate underpinning theoretical knowledge to confidently verify an expected adult death.
- To promote a safe and risk reduced environment when the practitioner is in any care setting.
- To offer support to relatives of the deceased or those who have cared for the deceased.
4 Duties (Roles and Responsibilities)

4.1 All Trust employed staff, including bank, agency and locum staff are responsible for adhering to Trust policies and guidelines including this policy. Clinical Managers, Nurse Specialists, Team Leads and Cluster Co-ordinators are responsible for cascading amendments of this policy to staff within the service they manage in a timely manner.

4.2 All Senior Nurses are responsible for ensuring implementation where appropriate within their area, and for ensuring all staff working in the area, adhere to the principles at all times.

4.3 The Clinical Managers, Nurse Specialists, Team Leads and Cluster Co-ordinators are responsible for providing expert advice in accordance with this policy, for supporting staff in its implementation and assisting with risk assessment where complex decisions are required.

4.4 Role of the practitioner verifying death
In order to provide appropriate support to relatives or those who have cared for the deceased, practitioners should familiarise themselves with any personal, cultural or religious requirements in relation to death. Information is available from the Chaplaincy Team or the online Major Faiths document. Religion or Belief

5 Definitions

- Verification – The establishment of the truth or correctness of something by investigation of evidence.

- Certification – To authorise or provide evidence of something with a certificate.

6 Policy and Procedure

6.1 Indications for Nurse Verification

The death must be expected and of an adult; for the purposes of this protocol, expected death can be defined as:

- A death of an adult patient where a DNACPR decision has been made and where the medical and nursing services have been involved in providing palliative/end of life care.

The suitability for Nurses to verify an expected adult death should be recorded in the Caring for the Dying Patient Document if it is being used to support the patients in last days/hours of life and/or on the Palliative Care Template on Systmone.
This policy does not apply to deaths of patients within continuing care and nursing home beds where care is provided by non-Trust staff.

6.1 Contra Indications to Nurse Verification

Nurses must not verify any of the following deaths:

- The death of a child (under 18 years)
- Deaths of unidentified persons
- Deaths of people not under obvious medical and/or nursing care
- Death which occurs within 24 hours of onset of illness, or where no firm clinical diagnosis has been made
- Deaths directly following post-operative or post invasive procedures
- Deaths which follow an untoward incident, fall or drug error
- Deaths which occur as a result of negligence or malpractice
- Any unclear or remotely suspicious death

6.2 Indications for Informing the Coroner in an Expected Death

There are certain circumstances in which the Coroner must legally be informed of an expected death. It is not possible to include a complete list of all situations within this protocol. The most common situation when the Coroner must be informed as soon as practicable is;

- When a patient has a diagnosis of Mesothelioma.

When a patient is expected to die, it is the responsibility of the Multi-Disciplinary team to identify and document the need for the Coroner to be informed, within the patients’ records and where appropriate discuss with the patient, relatives and carers prior to death. This may be recorded in the Caring for the Dying Patient document if it is being used to support the patient in the last days/hours of life.

6.3 The Process of Nurse Verification

The process of verification will be carried out by a Registered Nurse, who has undertaken Trust recognised training and completed the required competency tool/framework.

- The Nurse should check the patient’s nursing documentation and all other sources of information available to establish that the death is expected.

- The Nurse should establish that there are no contra indications to the verification of death.

- The Nurse should establish clinical signs of death using the following criteria:
  - Absence of carotid pulse for 1 minute
  - Absence of heart sounds for 1 minute
  - Absence of respiratory movements and breath sounds for 1 minute
  - Fixed and dilated pupils.
• The Nurse should confirm/inform the patient’s death with relatives/carers. If next of kin are not present, the Nurse should use details held in the nursing/medical records to contact the next of kin.

• The Nurse should advise on removal of the body by the undertaker.

• The Nurse should assess any known/disclosed Infection Prevention and Control risk and inform the relevant parties.

• If the Coroner needs to be involved, and death has occurred in the community, the Coroner’s deputy/Police will attend and the body will be removed to the appropriate hospital mortuary.

• If the death is suspicious, do not proceed with verification. Do not discontinue the Continuous Subcutaneous Infusion (CSCI), if in use. Ensure the environment is not disturbed. Contact the Police to attend.

6.4 Tissue Donation

Nurse to review nursing documentation to establish if the deceased had an expressed wish to make a tissue donation e.g. eye, skin, bone, heart valve or tendon. If so;

• Nurse to discuss with the family that the deceased had expressed a wish to make a tissue donation, and gain permission to contact the National Referral Centre for Tissue Donation on 24-hour pager 0800 4320559.

• The Tissue Service Co-ordinator will discuss donation and formal consent from the family via the telephone.

• In cases where the Coroner needs to be involved, the Tissue Service Co-ordinator will liaise with the Coroner.

6.5 Death in community setting of a patient known to community nursing services

• If the death was expected, subcutaneous drug(s) should to be discontinued and discarded as per Trust Waste Management policy.

• The relatives/carers should be advised to contact the patient’s General Practitioner on the next working day to obtain the Medical Certificate of Cause of Death (MCCD). Nurse to inform relatives/carers regarding obtaining death certificate from Newcastle Civic Centre.

• Nurse to provide information to the relatives/carers regarding D.W.P. (Department for Work and Pensions) booklet DWP1027 “What to do after a death in England & Wales”. Best practice is for the Nurse to provide the booklet.
• Complete the “Verification of Expected Adult Death by Registered Nurses” form (see Appendix 1).

• The General Practitioner and named Community Nurse should be notified of the patient’s death on the next working day Nurse to document Verification of Death on SystmOne.

6.6 Death of a patient in a hospital setting

The verifying Nurse will record the following details in the patient’s medical notes:
- The date and time of death
- That death has occurred
- That the next of kin have been informed/have not been informed (and what arrangements are being made to inform them)
- The names, designations and signature of Nurse verifying the death

• The Nurse should assess any known/disclosed Infection Prevention and Control risk and inform the relevant parties and complete the Infection Prevention and Control Notification sheet. (Access the Care of the Cadaver policy on the Intranet for further advice).

• Following care after death, the patient’s body may be transferred to the Funeral Directors or to the Mortuary if there is a known diagnosis of Mesothelioma.

• The Hospital Chaplaincy Team can be contacted Monday - Friday 8:30-17:00 via the on call phone: 24 48129 for help and advice. At weekends and evenings contact the hospital switch board on 2226161 and ask to be put in touch with Hospital Chaplaincy Team or appropriate Faith Leader.

• The Nurse in charge of the ward is responsible for ensuring communication to other members of the team (including the Consultant responsible for the patient’s care or the Doctor responsible for certifying the death) that death has occurred. Where this has not been communicated to relevant staff prior to the end of a shift, the Nurse in charge is responsible for ensuring that this information is passed on during the shift handover, and recorded in the patient’s notes citing any arrangements made with relatives. The name of the Doctor informed and the date and times of this communication should be entered in the nursing notes and medical notes. It will be the Doctor’s responsibility to examine the deceased in the mortuary/funeral directors, record the death in the medical notes, issue a Medical Certificate of Cause of Death and speak to relatives, if required to do so at an agreed time.

6.7 Informing Relatives of death

• The nurse should assess the communication needs of the patient’s relatives/carers, identify and provide where possible any communication
support required, for example, interpreters or British sign language interpreters.

- The Nurse to provide Information for the Bereaved booklet NFH2850’ to relatives/carers.

- Bereavement Officers will contact the relatives/carers to provide the Medical Certificate of Cause of Death.

7 Training

NMC registered Nurses including agency and bank staff who are employed by the Trust are responsible for accessing education in order to deliver safe effective care in the verification of death.

All NMC registered Nurses must ensure that they have been assessed and signed off competent against the relevant Trust competencies prior to carrying out the clinical procedure.

8 Equality and Diversity

The Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds. This policy has been appropriately assessed.

9 Monitoring

<table>
<thead>
<tr>
<th>Standard/process/issue</th>
<th>Monitoring and audit Method</th>
<th>By</th>
<th>Committee</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Death is an expected death</td>
<td>If a Datix is generated due to non-compliance of policy this will be discussed at the monthly Community Clinical Governance Steering Group meeting</td>
<td>Community practitioner(s): Community Nurse Manager, Senior Nurses &amp; Community Clinical Educator</td>
<td>Community Services: Clinical Governance Steering Group</td>
<td>Monthly</td>
</tr>
<tr>
<td>Tissue donation is documented</td>
<td>Data to be collected during real-time audits of end of life care twice yearly</td>
<td>Lead Nurse for EoLC</td>
<td>Community Services: Clinical Governance Steering Group End of Life steering Group</td>
<td>Biannually</td>
</tr>
<tr>
<td>Verification of death document is completed</td>
<td>On an annual basis an audit on the use and compliance of the policy will be undertaken</td>
<td>Cluster Coordinator Lead Nurse for EoLC</td>
<td>Community Services: Clinical Governance Steering Group End of Life steering Group</td>
<td>Annually</td>
</tr>
</tbody>
</table>
10 Consultation and development of this Guideline

Senior nursing and medical staff.

11 Implementation (including raising awareness)

Staff will be made aware of this policy through Nursing Forums and Directorate cascade mechanisms.

12 References

- Embracing Diversity in Mental Health Care: A resource on a Major Faiths in the UK.

13 Associated Documentation

- Care after Death Policy
- Care of the Cadaver
- Deprivation of Liberty Safeguards
- Lone Worker
- Respecting the religious and cultural needs of the patient
- Waste Management
Appendix 1

Verification of Expected Adult Death by Registered Nurses

GP / Consultant: Named Nurse:................................................................................................................

Patient Name: Patient Name:................................................................................................................

Next of Kin’s Name (print):................................................................................................................

Address: Address:..............................................................................................................................

Address: Address:..............................................................................................................................

Address: Address:..............................................................................................................................

Date of Birth: Date of Birth:...................................................................................................................

Telephone:........................................................................................................................................

NHS No: NHS No:..............................................................................................................................

Diagnosis: Diagnosis:...........................................................................................................................

Name(s) of those present at the time of death and relationship to patient (print): Name(s) of those present at the time of death and relationship to patient (print):

..........................................................................................................................................................

Clinical Recordings (please tick)

Pupil reaction absent · (both pupils fixed and dilated, not reacting to light)
Femoral or Carotid Pulse absent · (no pulse for 1 minute)
Respirations absent · (no breath sounds for 1 minute)
Heart sounds absent · (no heart sounds for 1 minute)

Time and date of death: ........................................................................................................................

Time and date of verification: ................................................................................................................

Name of Nurse (please print): Name of Nurse (please print):

Signature: Signature:............................................................................................................................

Subcutaneous Drug(s) discontinued and discarded, as per Trust / Organisation Protocol.

Name, address & telephone number of Funeral Director (if known)

..........................................................................................................................................................

Formal communication to patient’s GP within 24 hours (please complete)

Faxed Date & Time: Faxed Date & Time:..........................................................................................

Telephoned Date & Time: Telephoned Date & Time:........................................................................

Other please specify: Other please specify:......................................................................................
Appendix 2

Nurse Verification of Adult Expected Death

Patient dies

Was the death expected?

Yes

No

Is it documented that patient’s death can be verified by a nurse supported by the Caring for the Dying Patient Document?

Yes

No

Proceed to Nurse verification of expected adult death

Nurse informs relatives

Nurse to establish if deceased expressed a wish to donate tissues/organs

Yes

No

Does Coroner need to be informed? (eg. Mesothelioma)

Yes

No

Is it within working hours?

Yes

No

GP to inform Coroner

Contact Coroner deputy (Police) on 101

Coroner deputy (Police) will advise for removal of the body

Contact GP who may wish to view the body in the home prior to certification

Advise relatives/carers to contact undertaker to arrange for removal of the body

Ensure documentation completed as per protocol.
Ensure GP has been informed of the death, fax and by sending a hard copy by post.
If out of hours inform GP by telephone at start of next working day.

Do not discontinue syringe driver or disturb the environment

Contact GP and/or Police if appropriate on 101

Family agree to Nurse contacting National Referral Centre for Tissue donation on 24Hr Pager: 08004320559

Contact GP or NDUC out of hours

No

Yes

Nurse to establish if deceased expressed a wish to donate tissues/organs

Yes

No